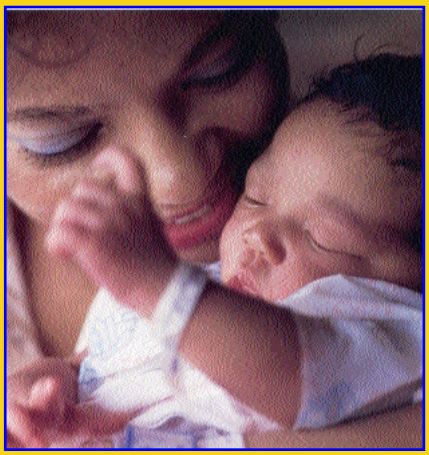
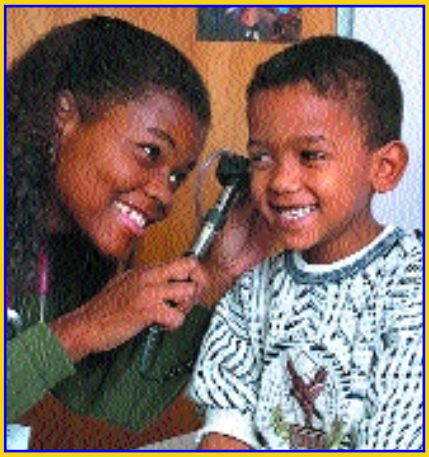
THE DISTRICT OF COLULMBIA

HEALTHY PEOPLE 2010

BIENNIAL IMPLEMENTATION PLAN

2003-2004





Government of the
District of Columbia
Anthony A. Williams, Mayor

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DOH
DEPARTMENT OF HEALTH

ACKNOWLEDGEMENTS

Herbert Tillery
Interim Director
Department of Health

Karyn Berry, MD, MPH
Interim Senior Deputy Director for
Primary Prevention and Planning

Paula Senior Fisher
Interim Senior Deputy Director
Health Promotions

Robert T. Maruca
Senior Deputy Director for
Medical Assistance Administration

Theodore J. Gordon
Senior Deputy Director for
Environmental Health Science and Regulation

Robert L. Johnson
Senior Deputy Director for
Substance Abuse Services Administration

Ivan Torres
Interim Administrator for
HIV/AIDS Administration

State Center for Health Statistics Administration (SCHSA)

Carl W. Wilson, Director, SCHSA

2010 Work Group

Patricia Theiss, Coordinator
Fern Johnson-Clarke, PhD
Joy Phillips, PhD
Luz Vega
John Sumner, PhD
Manzur Ejaz, PhD
Willis Bradwell

2010 Focus Area Program Liaisons

Sherry Billings
John Davies-Cole, PhD
Edwina Davis
Cheryl Eason
Elona Finkelstein
Gabriela Gonzales
Stephanie Harper, MD, MPP
Cheryl Iny
Paulette Jackson
Vincent Kofie, PhD
Deneen Long-White
Mehr Moradi
Corey Palmer
LaRah Payne, ScD
Robert Person
Juanita Reaves, PhD
Heather Reffert
William Robertson
Kimberley Turner

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*Section is to be developed

INTRODUCTION

WHAT IS THE HEALTHY PEOPLE 2010 PLAN?

In a recent presentation, Dr. David Satcher, the former US Surgeon General, described "Healthy People" as:

- "A comprehensive set of national 10-year health objectives
- Developed by a collaborative process
- Designed to measure progress over time
- A public health document that is part strategic plan, part national health data report, and part textbook on public health priorities."

The national Healthy People 2010 Plan, upon which the District's Plan is modeled, was introduced by the Department of Health and Human Services in January of 2000. The District of Columbia Healthy People 2010 Plan was developed by the Department of Health (DOH) for release by September of 2000. The Annual Implementation Plan (AIP) 2002 was developed by the DOH for distribution to the public by March of 2002. The AIP was foreseen as an opportunity for professionals and the lay public to join DOH program planners in tracking the progress of proposed strategies in attaining the short-term targets that serve as benchmarks for the timely attainment of the 2010 goals. Results of progress made in attaining the December 2002 targets in each of the 2010 focus area programs are presented in the AIP 2002 Progress Report. In view of competing DOH program priorities, by mid 2003 it was decided to expand the implementation period for the selected 2010 Objectives from one year to two years to allow more time for the charting of progress and indicated course corrections. Consequently, the implementation plan developed for 2003-2004 is a biennial plan and will be referred to as the Biennial Implementation Plan (BIP).

The role of the BIP remains the same as that of its predecessor, to present and evaluate strategies leading to the attainment of the DC Healthy People 2010 goals. It is a companion document to the District of Columbia Healthy People 2010 Plan. In both plans, the goals, objectives and recommended strategies are focused on improving the health of residents by eliminating health disparities and extending the years of healthy life for all residing in the District of Columbia by the Year 2010.

Implementation of the BIP is the responsibility of each program focus area administration and its program advisory committee in collaboration with local health care consumers and providers in both the public and private sectors. It is the practice of the DOH agencies to work through cooperative agreements with other governmental agencies responsible for categorical health planning, including the state agencies which deal with alcohol abuse, emergency medical services, mental health, and maternal and child health. This practice is reflected in the joint development of various components of the BIP. Implementation activities will also be facilitated through partnerships or collaborative agreements which the DOH agencies represented in the DC Healthy People 2010 Plan and related activities have established with other agencies and health groups in the community.

MANDATE

The mandate for developing and implementing the Healthy People 2010 Plan at the local level was derived from the federal *Healthy People 2010 Plan* produced by the US Department of Health and Human Services. The purpose of this national effort is to improve the health of all Americans by the year 2010. The *Healthy People 2010 Plan* was developed in an effort to address lessons learned from the *Healthy People 2000 Plan*. Designed to be more user friendly and inclusive, the *2010 Plan* has measurable objectives that are grounded in baseline data. Progress in meeting the goal or target can be tracked by referring to the baseline for any 2010 objective.

In an effort to eliminate health disparities, the federal plan sets the same 2010 target for all five of the standard racial and ethnic population groups. To measure progress in eliminating disparities in minority residential populations, the State Center for Health Statistics Administration (SCHSA) in collaboration with George Washington University Center for Global Health and key community-based organizations is developing a plan to conduct community health assessments that will provide these baseline data.

PHASES IN THE EVOLUTION OF THE 2010 PLAN

The development and implementation stages in the evolution of the 2010 Plan have been designated as Phase I and Phase II activities, respectively. In 1998, the Phase I Healthy People 2010 Planning and Development Committee was formed by the director of the SCHSA at the request of the DOH director to update the District's 2000 Plan and develop the new 2010 Plan. This committee consisted of the SCHSA's team of health statisticians and a public health advisor who would work with liaisons from each of the program focus areas to design, develop, produce, and implement the 2010 Plan in the District. This was done in collaboration with community representatives on program advisory groups and residents. The publishing of the District's Healthy People 2010 Plan and its Executive Summary signaled the conclusion of these Phase I activities.

In Phase II, the implementation and evaluation phase of activities, this committee has become the Healthy People (HP) 2010 Work Group. In 2001-2002, the HP 2010 Work Group, including health statisticians, public health advisor/program analyst and liaisons, developed and produced an Annual Implementation Plan (AIP) for 2002 which described recommendations that should contribute to the achievement of the goals and objectives in the District's Healthy People 2010 Plan. In developing the AIP for 2002, the program administrators and staff, in collaboration with their advisory committees gave priority to those objectives which were capable of having a significant impact on the health of residents, while maximizing the use of limited resources. The recommended actions and implementation strategies were designed to address the special needs of the residents of the District of Columbia. A Progress Report for the AIP of 2002 was developed by the end of 2002 to evaluate the progress in attaining the December 2002 Target for each of the 20 focus areas addressed in the AIP.

In addition to the time required for the production of the Progress Report to accompany each AIP, conflicting DOH program priorities necessitated the conversion of the foreseen AIP for 2003 into a biennial implementation plan (BIP) with a December 2004 Target. This document, the Biennial Implementation Plan for 2003-2004, presents selected DC Healthy People 2010 program objectives implemented in 2003 with strategies designed for attainment of a December 2004 Target.

BIP PRIORITIES

As in the AIP 2002, only 20 of the 21 Focus Areas in the District of Columbia Healthy People 2010 Plan are addressed in the BIP 2003-2004. When funding permits, the Oral Health section will be added. Focus Areas addressed in this edition of the BIP 2003-2004 are the following:

- Asthma
- Cancer
- Diabetes
- Disabilities
- Emergency Medical Services
- Environmental Health
- Health Care Finance
- Heart Disease and Stroke – which has become Cardiovascular Disease
- HIV/AIDS
- Immunization
- Injury/ Violence Prevention
- Maternal, Infant and Child Health
- Mental Health and Mental Disorders
- Nutrition and Overweight
- Primary Care
- Public Health Infrastructure
- Sexually Transmitted Diseases
- Substance Abuse
- Tobacco
- Tuberculosis

In order to determine the items to be included in the BIP 2003-2004, as in the AIP 2002, a priority selection process was used. During the selection process, consideration was given to the following issues:

- Strategies that would produce the greatest amount of impact with available resources.
- Consistency with the principle of focusing on a few priority objectives that are achievable rather than a large number of areas with limited prospects of success.
- Consistency with other related Focus Area program projects.

- Program areas in which there is much program staff expertise.
- Availability of staff and resources to successfully carry out activities.
- Potential cutbacks in federal health funding;

The BIP 2003-2004 has been developed according to progress made in reaching the December 2002 target, as well as information provided by the program staff in collaboration with its Program Advisory Committee. Public comment will be sought at a Public Hearing to be held prior to finalization of the document to ensure that community concerns are addressed. Progress in target attainment is to be described at the end of the two-year implementation period for each focus area in the BIP 2003-2004 Progress Report.

FORMAT AND ORGANIZATION

The goals and objectives in the twenty focus areas in this document are grouped according to the four federal Healthy People 2010 Plan Priority Actions:

- Promote Healthy Behaviors;
- Promote Healthy and Safe Communities;
- Improve Access to Quality Health Care Services
- Prevent and Reduce Diseases and Disorders

In the federal and District of Columbia (state) Healthy People 2010 Plans, the goals were conceived and stated as accomplishable by the year 2010. For ease of progress evaluation, the objectives are stated as measurable ones grounded in baseline data.

In the BIP 2003-2004, a December 2004 target is stated and the progress of strategies designed to attain the December 2004 target is monitored and reported in the corresponding Progress Report for that implementation period (2003-2004).

In each of the four Priority Areas, there are sections of related focus area programs. In the program sections, the 2010 goals and objectives to be addressed are stated. To clarify the significance of the chosen objectives, explanations of recommended actions and the rationale for these actions, are presented and followed by strategy statements and resource requirements. The recommended actions specify the tasks that are to be accomplished and by whom. The rationale statements provide the justification for various actions. The resource requirement section of the BIP presents the estimated amount of resources needed to accomplish the recommended actions.

In order to clearly identify the goals, objectives, and recommended actions in the BIP, a coding system has been developed. The same system was used in the AIP 2002. Each objective is identified by two components, the first of which is the number of the Focus Area – as listed in the Table of Contents - from which it comes and the second is the numerical sequence of the objective within the Focus Area. For example, Objective 2-1 is from the Focus Area on Tobacco Use (number 2 in the Table of Contents and in the

Chapter on Promote Healthy Behaviors) and is the first BIP objective listed under Tobacco use. *Objective 2-1 is as follows: Reduce to 18.5 percent the proportion of adults (18 years or older) who are current smokers. 20.9 percent of adults were current smokers in the District of Columbia in 2000, according to the Behavioral Risk Factor Surveillance Survey*.

MONITORING AND EVALUATION

Realizing that the actions taken over a one-year period represent only a fraction of the effort required to achieve the 2010 goal, the HP 2010 Work Group and program administrators believe that through the BIP process, unforeseen problems and unproductive strategies can be detected that could deter 2010 goal-seeking activities.

The actions taken toward implementing the BIP will be closely monitored and evaluated internally at the program level. Progress toward the December target will be monitored at the program level. At the end of November in the second year of the two-year implementation period, a Progress Report for that two-year period will be developed based on information from the program liaisons. The report will serve as the basis for an impact evaluation of each of the focus area programs in the four Priority Objectives in the BIP.

LEADING HEALTH INDICATORS

It should be noted that ten leading health indicators were selected by an interagency work group within the federal Department of Health and Human Services and reviewed in a process of regional and national meetings. These indicators were selected based on their ability to motivate action, the availability of data to measure their progress and their relevance to broad public health issues. These indicators are the following:

1. Physical activity
2. Overweight and Obesity
3. Tobacco Use
4. Substance Abuse
5. Responsible Sexual Behavior
6. Mental Health
7. Injury and Violence
8. Environmental Quality
9. Immunization, and
10. Access to health care

In this BIP, those 2010 focus areas included among the above-listed indicators will be identified. Local data on the 2010 objectives that are related to the ten leading health indicators are presented in a separate document, A Chart Book, which is to be available by the fall of 2004.

PROMOTE HEALTHY BEHAVIORS

1. NUTRITION AND OVERWEIGHT
2. TOBACCO USE

Focus Area: Nutrition and Overweight

Overweight and obesity are leading health indicators.

1) **2010 Goal 1-1:** The proportion of African American infants and children up to five years of age in the Women, Infants, and Children (WIC) Program with a hemoglobin of 11.1 gm/dl or less as registered at subsequent certification visits will have been reduced by 2 %.

Objective 1-1: Reduce the proportion of infants and children up to the age of five years in the Special Supplemental Nutrition Program for WIC registering a hemoglobin value of 11.1 gm/dl or less at subsequent certification visits by 2 %**.**

Baseline 1-1: According to FY 2002 WIC participation data for the District of Columbia, the average percentage for low iron classification is 20.3 % in children under the age of 5 years. There is a great deal of variation between race and ethnic groups; for instance, the prevalence of anemia in the Asian/Pacific Islander and Hispanic population is 15.3% and 14.0% respectively, while the rate of anemia for African American children is 22.4%. Over the last five years, the anemia rates have declined by 7% - a direct result of a comprehensive CDC Cooperative Agreement grant.

RECOMMENDED ACTION:

- Participants and their caregivers will be targeted as agents of change to improve iron levels;
- Nutrition education, iron-rich supplemental foods, and a commitment by the WIC participant to behavioral changes are necessary to achieve this goal;
- Each participant will have a hemoglobin or hematocrit measurement performed at least once a year. Participants with low iron levels will be informed both orally and in writing, and they may have an additional test performed within a given year.

RATIONALE:

- Relevant nutrition education will be provided for each client to positively impact each client's health behavior;
- Opportunities for each client to sample some of the iron-rich foods can positively impact their iron level;
- Follow-up testing will permit both clinician and participant to keep track of progress.

STRATEGY:

- Nutrition education on the need for improved iron levels before, during and after pregnancy will be provided for each client;
- Iron-rich food sampling opportunities will be provided;
- Follow-up testing of iron levels will be conducted on each client within program parameters;
- Accurate measurements will be taken, so that the collected data reflect the true picture of anemia prevalence;
- Establishment of research collaborations to more closely examine (1) the type of anemia present in the DC WIC child population and (2) societal and environmental determinants (and causes) that might contribute to a high prevalence of anemia in certain geographic areas in Washington, DC.

RESOURCE REQUIREMENTS:

- Sufficient registered dietitians;
- Funding for innovative and culturally appropriate educational materials;
- Staff for tracking and follow-up;
- Staff to help with research-related tasks.

December 2004 Target: By December 2004, the proportion of (infants and children under five years of age) registering low iron levels in the blood will be decreased by 2% in African American infants and children from 22 % to 20%.

2) **2010 Goal 1-2:** The rates for breastfeeding and the duration of breastfeeding among women enrolled in the WIC Program in the District of Columbia will have been increased to 45 %.

Objective 1-2: Increase the proportion of low-income residents enrolled in the Women, Infants and Children (WIC) program who breastfeed their babies in the early postpartum period to 45 % and increase to at least 25 % the proportion of women who breastfeed for up to 6 months.

Baseline 1-2: According to 2002 data, currently 40 % of women enrolled in WIC initiate breastfeeding, 21 % continue breastfeeding up to 6 months, but only 12 % continue the practice past six months postpartum (up to 12 months).

RECOMMENDED ACTION:

- Face-to-face contacts for breast-feeding education during pregnancy and after pregnancy are recommended. Each contact will consist of individual assessment, counseling and referrals.

- The majority of all pregnant WIC participants will receive at least one contact for breast-feeding education during pregnancy by either a nutritionist or a breastfeeding peer counselor;

- The majority of postpartum participants will receive at least two nutrition education contacts;

- Ensuring that the WIC clinic environment is breastfeeding friendly and that all employees give uniform breastfeeding messages.

RATIONALE:

- According to Dr. David Satcher, the former Surgeon General of the United States, who sponsored the Health and Human Services Blueprint for Action on Breast-feeding, infants who are breastfed experience a lower incidence of infections, have an enhanced immune system, and are at reduced risk for chronic diseases;

- Improved maternal health and societal benefits are also strong reasons to increase the incidence and duration of breastfeeding.

STRATEGY:

- The WIC Program will utilize registered dietitians, lactation consultants, and peer counselors to educate WIC families about the importance of breastfeeding;

- Educators will use creative, culturally appropriate education strategies that include computer-assisted learning units, such as kiosks;

- All staff coming in contact with WIC clients will be trained in basic breastfeeding knowledge and counseling skills.

RESOURCE REQUIREMENTS:

- Strong partnerships with local birthing centers, hospitals, lactation consultants, and local breastfeeding groups will ensure that all available resources are tapped. These partnerships will be fostered by providing breastfeeding training opportunities to a variety of health professionals that are involved with breastfeeding issues, such as pediatricians, obstetricians, lactation consultants, nurses, and social workers;

- Sufficient staff, including peer counselors who can make home visits and otherwise educate participants in a private setting;
- Sufficient peer counselors available to breastfeeding mothers in the WIC program.

DECEMBER 2004 TARGET: By December 2004, 45 % of clients will breastfeed their babies in the early postpartum period and at least 25 % will continue until the baby has reached 6 months of age.

3) **2010 Goal 1-3.1:** Forty-five percent of WIC participants presenting for a second nutrition contact are taught about the benefits of physical activity and the benefits of good nutrition and regular exercise as life-long disease prevention strategies. Lesson plans on these lifestyle concepts will be expanded in the currently existing "Healthy Eating" nutrition section of the core WIC Nutrition Education Curriculum.

Objective 1-3.1: Reach 45 % of WIC participants with lessons on the benefits of physical activity, the hazards of obesity, and the benefits of good nutrition and regular exercise as life-long disease prevention strategies that are part of the core WIC Nutrition Education curriculum.

Baseline 1-3.1: As of 2001, WIC participants are being taught about the "Right Weight" and "Exercising" as part of the healthy eating core nutrition section, but as of yet no major core nutrition section has been dedicated to obesity, its long-term adverse effects on health and prevention strategies. Based on 2002 WIC reports, approximately 12.8 % of all children between 2 and 5 years of age are documented as being at or above the 95th percentile in weight for height which is slightly below the national average of 13.1%. The percentage of children at risk of being overweight is 13.5%.

- A comprehensive section on overweight/obesity in adults as well as children, its long-term implications for health, and the benefits of good nutrition and regular exercise as preventive strategies should be developed for the WIC core curriculum. It should build upon the existing content of the lesson plans on weight management and physical activity in the healthy eating core nutrition category of the WIC nutrition core curriculum. This section should contain culturally sound messages that specifically target the Hispanic and Asian communities, as overweight/obesity is much more prevalent in Hispanic and Asian/ Pacific Islander children up to the age of 5 years (20.0% and 11.4%, respectively in 2002) than in other racial /ethnic groups. All WIC participants should receive information on obesity-related topics, if there are no other pressing nutrition-related issues that need to be addressed first;

- Ensured participation of nutrition staff in the statewide implementation of the Tri-City Challenge, as well as any other health campaigns that address obesity-related health issues by delivering sound health messages.

RATIONALE:

- Obesity has become one of the major nutrition-related issues facing our nation, because of its long-term adverse implications for health. In the District, increasing obesity numbers in parts of the population are countered by a relatively high prevalence of underweight in African-American children below the age of 5 enrolled in the WIC program in the District of Columbia (7.6% compared to 5.4% nationwide according to 2002 PedNSS data);

- Left unchecked, the increasing incidence of obesity among children, as well as adults, will negatively impact rates of diabetes and cardiovascular disease.

STRATEGY:

- Develop a section on obesity for inclusion in the Food Stamp Nutrition Education Plan.

- Include the following strategies:
  - Food Stamp Nutrition participants should be encouraged to eat balanced meals;
  - All participants should undergo regular weighing on-site at certification visits;
  - Participants should be strongly encouraged to adopt the preventive strategies presented in the Food Stamp Nutrition Education Plan.

- Use the section on obesity as a teaching guide to ensure that all participants are instructed about obesity, the significance of its threat to health and the benefits of good nutrition and regular exercise in lowering the risk for heart disease, diabetes and weight-related disorders.

RESOURCE REQUIREMENTS:

- Funding for the development and testing of educational and promotional materials;
- Increased staffing to participate in citywide health fairs, in order to promote overweight-related behavior changes to low-income families.

DECEMBER 2004 TARGET: By December 2004, a chapter on obesity will be integrated into the healthy eating core nutrition category. Clients will be counseled on well-balanced diets, the need to maintain a healthy weight, benefits of being physically active and ways of increasing physical activity, as well as on proper diet variety and quantity.

4) **2010 Goal 1-3.2**: 10% of the Food Stamp Nutrition Education Plan target audience will attend an education session on physical activity, the hazards of obesity, and the benefits of good nutrition and regular exercise as a life-long prevention strategy.

Objective 1-3.2: Reach 10 % of the Food Stamp Nutrition Education Plan target audience with an education session on physical activity, the hazards of obesity, and the benefits of good nutrition and regular exercise as a life-long prevention strategy.

Baseline 1-3.2: As of 2003, the Food Stamp Program participants were not included in the DOH WIC Program. The Food Stamp Nutrition Education Plan has been developed for this audience.

RECOMMENDED ACTION:

- A section on obesity, its long-term implications for health, and the benefits of good nutrition and regular exercise as preventive strategies should be developed for inclusion in the Food Stamp Nutrition Education Plan which all Food Stamp participants will receive.

- A proposed schedule of events is the following:
  - Pilot testing of curriculum done by December 2003;
  - Training provided to project partner liaisons by January 2004;
  - Implementation by February 2004.

RATIONALE:

- Obesity has become one of the major nutrition-related issues facing our nation, because of its long-term adverse implications for health.

- Left unchecked, the increasing incidence of obesity among children, as well as adults, can negatively impact rates of diabetes and cardiovascular disease.

STRATEGY:

- Develop a section on obesity for inclusion in the Food Stamp Nutrition Education Plan;

- Include the following strategies:
  - Food Stamp participants should be encouraged to eat balanced meals;
  - All participants should undergo regular weighing on-site at certification visits;
  - Participants should be strongly encouraged to adopt the preventive strategies presented in the Food Stamp Education Plan.

- Use as a teaching guide to ensure that all participants are instructed about obesity, the significance of its threat to health and the benefits of good nutrition and regular exercise in lowering the risks for heart disease, diabetes and weight-related disorders.

RESOURCE REQUIREMENTS:

- Funding for the development and testing of educational and promotional materials.

DECEMBER 2004 TARGET: As of December 2004, clients will be counseled on well-balanced diets, the need to maintain a healthy weight, benefits of being physically active and ways of increasing physical activity, as well as proper diet variety and quantity.

Focus Area: Tobacco Use

Tobacco Use is a Leading Health Indicator.

1) **2010 Goal 2-1:** No more than 18.5% of adults are current smokers.

2010 Objective 2-1.1: Reduce to 18.5% the proportion of adults (18 years or older) who are current smokers.

Baseline 2-1.1: 20.9 % of adults were current smokers in the District of Columbia in 2000. (Behavioral Risk Factor Surveillance Survey or BRFSS)

RECOMMENDED ACTION:

- The goal of the chapter on Tobacco Use in the federal *Healthy People 2010 Plan* is the curtailing of tobacco use in order to reduce illness, disability, and death related to tobacco use and exposure to second hand smoke.

- Conduct anti-smoking educational campaigns designed to bring about behavior modification resulting from changes in the attitude and behavior of smokers as they become aware of the health risk and burden of disease associated with smoking;

- Determine the level of knowledge among current smokers concerning the adverse health effects of smoking.

RATIONALE:

- Tobacco use is the single most preventable cause of death and disease in our society (Surgeon General's Report in 2000);

- In 1997, the death rate from lung cancer in the District of Columbia was 40.8 per 100,000 people compared to the national average of 37.3 per 100,000 people. Death rates from lung cancer are among the clearest indicators of the burden of tobacco use);

- Tobacco use is addictive and consequently, it is very hard to quit smoking. Smokers often need education, counseling and/or medical intervention to overcome their addiction to tobacco and nicotine.

STRATEGY:

- Provide anti-tobacco educational materials to District residents;

- Promote smoking cessation programs in the community and coordinate efforts with current cessation programs through promotions and incentives for attendees;

- Promote cessation Hotline services;

- Implement an environmental tobacco smoke (ETS) campaign, targeting adults and restaurant owners, with emphasis on the dangers of second-hand smoke.

RESOURCE REQUIREMENTS:

- Continuation of the Comprehensive State-based Tobacco Use Prevention and Control Program funded by the federal Centers for Disease Control and Prevention (CDC);
- Continued partnership with organizations involved in tobacco control.

DECEMBER 2004 TARGET:

- As of December 2004, 11,000 of the adult population will be reached through anti-smoking educational campaigns.

- As of December 2004, licensed restaurant owners in the District of Columbia will be reached through anti-smoking educational campaigns and encouraged to go smoke-free.

2) **2010 Goal 2-1.2:** No more than 15% of youth in the District of Columbia are current smokers.

2010 Objective 2-1.2: Reduce to 15 % the proportion of youth (under 18 years of age) who are current smokers in the District of Columbia.

Baseline 2-1.2: 17% of youth in the District of Columbia were current smokers in 1999 (Youth Risk Behavior Survey or YRBS).

RECOMMENDED ACTION:

Prevention efforts traditionally concentrate on bringing about a change in the attitudes and behaviors of youth who are current smokers.

RATIONALE:

- Smoking is estimated to cause 4,927 District of Columbia residents to die prematurely (*CDC Investment in Tobacco Control - State Highlights 2001);*

- Tobacco use among young people remains one of the most critical health priorities (Surgeon General's Report 2000);

- Cigarette smoking among friends, peers, siblings and others from the young person's immediate environment is consistently associated with smoking initiation;

- The influence of friends and peers seems to have considerable influence on attitudes and decisions regarding smoking.

STRATEGY:

- Prevent youth smoking initiation by:

  - Conducting workshops for youth groups on the hazards of tobacco use.

  - Initiate the process with DC Public Schools (DCPS) to administer the Youth Tobacco Survey in the District's Public Schools at the Junior High, Middle School. And High School levels;

  - Review, analyze, and publish the results of the 2000 survey.

RESOURCE REQUIREMENTS:

- Continuation of the Comprehensive State-based Tobacco Use Prevention and Control Program funded by the CDC;
- Continued partnerships with the District's Public Schools, recreation centers, organizations that provide services for youth.

DECEMBER 2004 TARGET: As of December 2004, 4000 of the youth population will be reached through educational anti-smoking efforts, including workshops and youth-led activities.

PROMOTE HEALTHY AND SAFE COMMUNITIES

3. ENVIRONMENTAL HEALTH AND FOOD SAFETY

4. INJURY/ VIOLENCE PREVENTION

5. PEDIATRIC DENTAL HEALTH (to be included in the AIP for 2003)

Focus Area: Environmental Health

Environmental Quality is a Leading Health Indicator.

1) **2010 Goal 3-5**: 2,000 units in the District of Columbia have been tested for lead-based paint.

2010 Objective 3-5: Perform testing for lead-based paint in 2,000 homes in the District of Columbia. Testing is dependent upon whether or not a child within the unit has been identified as having elevated blood lead levels or if the property owner requests abatement work to be done.*

Baseline 3-5: In the District, 1,150 housing units were tested between 1991 and 1996.

*The Department of Housing and Community Development also inspects homes for lead through the US Department of Housing and Urban Development's Healthy Homes program.

Recommended Action: Continue to test for lead-based paint within those housing units where a child with elevated blood lead levels resides or where the property owner has requested abatement work and therefore requires testing.

Rationale: The District possesses an aging housing stock of which 95% of residences were built prior to 1980; the use of lead-containing paint in residences was not banned until 1978.

Strategy:

- Continue to collaborate with the lead screening program, which screens children up to age 6 for elevated blood lead levels, to identify units requiring testing;
- Additionally, continue to accept property owner requests for testing.

Resource Requirements: No additional resources are required at this time.

December 2004 Target: By December 2004, there will be 600 units tested for lead-based paint.

2) **2010 Goal 3-12**: At least 80 % of pharmacies dispensing prescription medications in the District use linked systems to provide alerts to potential drug reactions from medications dispensed by a different source to individual patients.

2010 Objective 3-12: Increase to at least 80 % the proportion of pharmacies dispensing prescription medications that use linked systems to provide alerts to potential adverse drug reactions from medications dispensed by a different source to individual patients.

Baseline 3-12: In 1993, nationally 95 % of pharmacies utilized linked computers. Within the District of Columbia, as of 2000, 75% of pharmacies utilized linked computers.

Recommended Action: Ensure that the remaining 25% of pharmacies within the District of Columbia have linked computer systems.

Rationale: Linked computer systems provide customers with alerts to potential adverse reactions from medications prescribed for them.

Strategy: Collaborate with the Washington Pharmacy Association to work with the regulated independent pharmacies to obtain compliance.

Resource Requirements: No additional resources are required.

December 2004 Target: By December 2004, there will be a 8% increase in the percentage of pharmacies utilizing linked computer systems.

3) **2010 Goal 3-11**: The 1999 Food Code for institutional food operations has been adopted and implemented, as has the new uniform food protection code.

2010 Objective 3-11: Adopt and implement the 1999 Food Code for institutional food operations and the new uniform food protection code that sets recommended standards for regulation of all District food operations.

Baseline 3-11: In November 2002, the Council of the District of Columbia passed the new food regulations, adopting the 1999 US National Food Code.

Recommended Action: Implement the new food regulations passed by the DC Council.

Rationale: The new regulations make changes to the previous ones and require that the regulated community be informed of new requirements.

Strategy: Information will be provided to the regulated community by four means:

1) Forming a collaboration with the Washington Restaurant Association;

2) Distributing informational flyers;

3) Attending community meetings; and

4) Making the new information easily accessible via the internet.

In addition, special attention will be given to food-establishments in ethnic communities, such as Chinese restaurants and their owners.

Resource Requirements: No additional resources are required.

December 2004 Target: By December 2004, 2,500 informational flyers will have been distributed and 7 community meetings attended.

Focus Area: Injury and Violence

Injury and Violence are Leading Health Indicators.

1) **2010 GOAL 4-6.1:** An Injury Trauma Registry has been established at the Department of Health (DOH) to which data on injury cases from hospital emergency rooms, trauma centers, and ambulatory clinics are reported on a regular basis.

OBJECTIVE 4-6.1: Establish an Injury Trauma Registry at the Department of Health (DOH) to which data on injury cases seen at hospital emergency rooms, trauma centers and ambulatory clinics are reported on a regular basis.

4-6.1a: Submit legislation entitled "Injury Reporting Bill" mandating development of Trauma Registry at DOH to General Counsel's Office for review and enactment by City Counsel.

4-6.1b: Upon approval, notify administrators of *(all District-based)* injury-treatment sites (hospital emergency rooms, trauma centers, and ambulatory clinics) of announcement of establishment of Injury Trauma Registry in the District of Columbia located within DOH.

4-6.1c: Assist in drafting of regulations by General Counsel's Office and alert trauma treatment center administrators to announcement of regulations in the DC Register.

4-6.1d: Send official notification of establishment of Injury Trauma Registry and regulations mandating reporting to DOH to all trauma treatment sites in the District of Columbia.

4-6.1e: (1) In the interim, establish Advisory Committee to oversee the design and data intake and storage capability of the Injury Trauma Registry.
(2) Establish Memoranda of Agreements with (all District-based) injury-treatment sites (hospital emergency rooms, trauma centers, and ambulatory clinics) to voluntarily submit injury information to the DOH Injury Trauma Registry prior to the passing of the "Injury Reporting Bill."

4-6.1f: Hire and train the staff (data manager and two data entry clerks) for the Registry.

BASELINE 4-6.1: As of July, 2001, there is no Trauma Registry at DOH to which data are reported on a regular basis. Baseline data regarding the steps leading to the establishment of the Registry are to be added.

RECOMMENDED ACTION:

- Submit an "Injury Reporting Bill" to Office of the Legal Counsel for review and submission to City Council for approval and enactment:
  - Mandating the formation of an Injury Trauma Registry at DOH to contain data on intentional and unintentional injuries to District residents;
  - Mandating injury treatment sites (hospital emergency rooms, trauma centers, and ambulatory clinics) to report all injuries to the DOH; and
  - Specifying regulations for the regular reporting on cases seen at hospital emergency rooms, trauma centers, and ambulatory clinics.

- Establish Memoranda of Agreement with injury-treatment sites (hospital emergency rooms, trauma centers, and ambulatory clinics) to voluntarily submit injury information to DOH prior to the passing of the legislation;

- Develop an Injury Trauma Registry Task Force comprised of professionals with expertise in injury, as well as disability, for both pediatric, adolescent, adult, and geriatric patients.

RATIONALE:

The establishment of an injury trauma registry at DOH will permit:

- Regular reporting to the public on the incidence and types of injuries (both intentional and unintentional) suffered by residents;

- Development of epidemiological studies regarding the nature and origin of the various types of trauma injuries; and

- Provision of information on trauma injuries upon which the strategic planning of emergency response mechanisms can be based.

STRATEGY:

- Collaboration with the Office of Emergency Health and Medical Services (OEHMS) to develop a comprehensive system to store trauma data, intentional and unintentional injury data, and an integrated system with all injuries regardless of severity.

- Collaboration with the Trauma Centers and Emergency Departments Committee on the development of a comprehensive integrated system for injury.

- Utilize the Injury Trauma Registry Advisory Team Trauma Centers and Emergency Departments Committee to review the current "Injury Reporting Bill" and make recommendations.

- Revise the current impact statement for City Council consideration.

- Revise the "Injury Reporting Bill" to include the recommendations of the Advisory Team.

- Submit the revised, proposed "Injury Reporting Bill" to the Office of the Legal Counsel for review and submission to the City Council for consideration and enactment. The bill was successful in target attainment. However, according to response of Chief Financial Officer, DOH funds were not sufficient from FY 2002 through FY 2005 budget to support the implementation of the proposed legislation.

- Develop Memoranda of Agreement with the injury treatment sites (i.e., hospital emergency rooms, trauma centers and ambulatory clinics) for the purpose of reporting injury data to the DOH on a voluntary basis prior to the enactment of the legislation. The Division is currently working with trauma centers regarding certification by the DOH/OEHMS. Certification must be in place prior to the trauma centers agreeing to voluntarily commit to the sharing of data.

- Utilize the intentional injury surveillance database as the initial information for the Injury Registry. Steps are being taken to obtain the former DC General Hospital Trauma Center database for utilization in the development of baseline data on injury in the District of Columbia.

- Work with the Advisory Teams to develop an enforcement clause/protocol for consideration by the City Council.

RESOURCE REQUIREMENTS:

- Hire staff - data manager and two (2) data entry clerks. There was an unsuccessful effort in 2002, due to lack of funding.

DECEMBER 2004 TARGET: By December 2004, the process of establishing an Injury Trauma Registry at the DOH is 85% complete. This percentage takes into consideration the time required for the legislative processing by the DOH Office of the Legal Counsel and the City Council. Also, consideration is give to the timeline for establishing Memorandums of Agreement between the healthcare facilities, subordinate agencies and the DOH.

2) **2010 GOAL 4-6.2:** Ninety percent of hospital emergency rooms, trauma centers, and ambulatory clinics in the District of Columbia report data on injury cases seen on-site to the DOH Injury Trauma Registry on a regular basis in compliance with the regulations.

OBJECTIVE 4-6.2: Increase to 90 percent the proportion of emergency rooms, trauma centers, and ambulatory clinics reporting data on intentional and unintentional injuries to residents seen to the DOH Injury Trauma Registry in compliance with HIPPA Regulations.

BASELINE 4-6.2: Baseline data to be determined. All level one trauma centers (of which there are three) have registries that collect data on the external causes of injury, but are not mandated to report this information to the DOH. The number of treatment sites voluntarily reporting data to the DOH on intentional and unintentional injuries seen on-site can be considered as a baseline to which more sites can be added after reporting becomes mandatory.

RECOMMENDED ACTIONS:

Develop Memoranda of Agreement outlining collaboration and commitment of the Bureau of Epidemiology and Health Risk Assessment, DOH Emergency Medical Services Administration, State Center for Health Statistics Administration, Metropolitan Police Department, and the
DC Fire and Emergency Medical Services Department in the reporting of injury information regarding both mortality and morbidity.

RATIONALE:

- Information obtained from the Injury Trauma Registry will allow the Department of Health (DOH) to make recommendations to policymakers and trauma care facility management planners to make decisions on resource allocations within in the various city wards.

- The establishment of a Trauma Registry at DOH will enable the government to inform District residents of the ongoing trends in intentional and unintentional injuries in terms of extent of morbidity and mortality.

STRATEGY:

- Create a Trauma Registry Task Team to assist in assessing the completeness of current reporting;

- Assess the data coding practices of all hospital emergency rooms, trauma centers, and ambulatory clinics;

- Assess the database (i.e., software) of each hospital emergency room (ER), trauma center, and ambulatory clinic for compatibility;

- Select appropriate software for the Trauma Registry system that will allow the electronic linkage of information between the DOH and treatment sites (hospital ER, trauma center, and ambulatory clinic);

- Develop a uniform reporting system for trauma injuries that will be mandatory for all trauma treatment sites (hospital ER, trauma centers, and ambulatory clinics);

- Mandate the reporting of all trauma injuries to the DOH by District hospitals, trauma centers, and ambulatory clinics.

RESOURCE REQUIREMENTS:

- Legislation that mandates the regular reporting by all District of Columbia hospital emergency rooms, trauma centers, and ambulatory clinics of intentional and unintentional trauma injury cases seen on-site to the Injury Trauma Registry at the DOH;
- The inclusion of funding in the District of Columbia budget that ensures the sustainability of the Injury Trauma Registry at the DOH;
- Hiring of Staff - Data Manager and two (2) Data Entry Clerks;
- Budget line item for staff salaries and fringe benefits;
- Budget line item to maintain registry (including software, equipment and maintenance);
- Budget line item for staff training;
- Budget line item for IT assistance;
- Budget line item for report analysis, development and dissemination.

DECEMBER 2004 TARGET: By December 2004, 85 percent of the injury treatment sites report data to the DOH Injury Trauma Registry by one of the following mechanisms: 1) As mandated by the enactment of the "Injury Reporting Bill" or 2) voluntarily through Memoranda of Agreements stating their commitment to participate in the reporting.

Focus Area: Pediatric Dental Health

This focus area program is awaiting development. Whenever Pediatric Dental Health is adopted for development by a program person working in the topic area, it will be included in the next Biennial Implementation Plan.

EXAMPLE: The below-listed 2010 Goal 5-3 is one of 8 presented in the DC HP 2010 Plan.

GOAL 5-3: At least 70% of children ages 8 and 14 years of age have received protective sealants in permanent molar teeth.

OBJECTIVE 5-3: Increase to at least 70% the percentage of children ages 4-8 years of age who have received protective sealants in permanent molar teeth.

BASELINE 5-3: Nationally, between 1988 and 1994, 23% of 8-year-olds and 24% of 14 year-olds received sealants in permanent molar teeth. *Local data to be added when available.*

RECOMMENDED ACTION:

(To be added by program staff)

RATIONALE:

(To be added by program staff)

STRATEGY:

(To be added by program staff)

RESOURCE REQUIREMENTS:

(To be added by program staff)

DECEMBER 2004 TARGET: *(EXAMPLE)*

By December 2004, the proportion of District children who have received protective sealants in permanent molar teeth has increased from - % to - % for 8 year olds and from - % to - % for 14 years olds *(local data to be added).*

IMPROVE ACCESS TO QUALITY HEALTHCARE SERVICES

6. PRIMARY CARE

7. EMERGENCY MEDICAL SERVICES

8 HEALTH CARE FINANCE

9. MATERNAL, INFANT AND CHILD HEALTH AND FAMILY PLANNING

10. PUBLIC HEALTH INFRASTRUCTURE

Focus Area: Primary Care

Access to Health Care is one of the leading health indicators.

1) **2010 Goal 6-3:** Access to care has been increased by increasing the number of designated Health Professional Shortage Areas for primary, dental and mental health care in the District of Columbia from 9 to 20.

Objective 6-3 Increase access to care by increasing the number of Health Professional Shortage Areas (HPSA) in the area of primary, dental and mental health care in the District of Columbia from 9 to 20.

Baseline 6-3: In 2001 in the District of Columbia, there were 4 service areas, two population groups and 1 facility designed for primary medical care. There was one population group for dental health care and 1 service area for mental health care.

RECOMMENDED ACTION:

- Assess health care delivery services at the census tract level throughout the District of Columbia and
- Recommend health service areas for designation status to the Health Resources and Services Administrations Division of Shortage Designation.

RATIONALE:

HPSA designation status is necessary for National Health Service Corps. Provider placement, J-1 Visa waiver physician placement and some grant funding resources.

STRATEGY:

- Determine the population residing in census tracts by number of residents, economic status, and age;
- Determine the number of primary care, mental health and oral health providers available to serve the populations residing in each census tract;
- Determine the population to provider ratio;
- Develop a study of the area which encompasses findings;
- Recommend designation status accordingly.

RESOURCE REQUIREMENTS:

- 2 FTEs for staffing needs
- Computer software and hardware for database information and report preparation

DECEMBER 2004 TARGET: By December 2004, 1 additional dental care services area, and 1 additional mental health services area will be established.

2) **2010 Goal 6-1**: Access to care and quality of care for the District of Columbia's uninsured and underserved population have been improved, due to the increase in the number of National Health Service Corps (NHSC) sites from 14 to 25 and healthcare provider placements from 15 to 55.

2010 Objective 6-1: Increase access to care and improve quality of care for the uninsured and underinsured populations in the District of Columbia by increasing the number of National Health Service Corps (NHSC) sites from 14 to 25 and healthcare provider placements from 15 to 55.

Baseline 6-1: As of 2002, there are 14 designated NHSC sites and 15 NHSC healthcare providers placed in the District of Columbia.

RECOMMENDED ACTION:

- Recommend and recruit healthcare facilities located in Health Professional Shortage Areas to become NHSC sites;

- Facilitate the placement of NHSC healthcare providers seeking to practice in the District of Columbia;

- Ensure that the NHSC healthcare providers are strategically placed throughout the District of Columbia, especially in the most vulnerable communities.

RATIONALE:

- The National Health Service Corps increases access to health care and improves the quality of heath care for the District of Columbia's underserved and indigent populations.

- The NHSC contributes to the District's effort to attain the goal of 0% disparity and 100% access.

STRATEGY:

- Identify healthcare facilities located in Health Professional Shortage Areas that serve the indigent population;

- Provide NHSC workshops for healthcare providers to recruit future sites and to disseminate informational materials about the program;

- Facilitate the placement process for NHSC healthcare providers in the District of Columbia;

- Recommend NHSC site.

RESOURCE REQUIREMENTS:

- 1 FTE for staffing needs;
- Computer software and hardware for database information;
- Informational materials and Audio/Video equipment for workshops

DECEMBER 2004 TARGET: By December 2004, 2 new NHSC sites will be recommended and 5 NHSC healthcare providers will be placed in the District of Columbia.

Focus Area: Emergency Health and Medical Services

Update on the Emergency Health and Medical Services Administration (EHMSA)

The year 2002 brought several changes to the EHMSA. The changes are:

- In the spring of 2002, the EHMSA was awarded a substantial grant from CDC for Public Health Preparedness in Response to Bioterrorism.
- In June of 2002, EHMS was expanded from an office to an administration, the Emergency Health and Medical Services Administration (EHMSA) by action of the Acting Director of the DOH
- The CDC grant has enabled the new EHMSA to develop four administrative components: "EMS Program, Emergency Operations, Epidemiology and Surveillance, and Public Health Laboratory."
- The new administration has a new mission statement. "The mission of the Emergency Health and Medical Services Administration is to assure the delivery of the highest quality emergency medical and trauma care services and to plan, implement and direct the emergency responses for the DOH."
- Consequently, the EHMSA is responsible for the health component of the DC Emergency Support Function #8, "Health and Medical." In addition, EHMSA has become the lead agency in the District of Columbia for Public Health Bioterrorism Preparedness and Planning.

1) **2010 GOAL 7-2.3:** An Injury Trauma Registry has been established and implemented at the Department of Health (DOH).

OBJECTIVE 7-2.3: In collaboration with the DOH Injury Program, establish a District of Columbia Trauma Registry that captures all relevant data on utilization, levels of uncompensated trauma care, and indicators of the quality of trauma care.

BASELINE: 7-2.3: As of July 2001, there is no Trauma Registry at DOH to which data are reported on a regular basis. The Trauma Registry probably will not be established at DOH before 2004.

RECOMMENDED ACTION:

- Before a Trauma Registry can be established, a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis of the trauma system should be conducted.

- The SWOT Analysis will serve to identify the data the DOH needs to collect from the trauma centers, Medical Examiners Office and the EMS Bureau.

RATIONALE:

The establishment of an Injury Trauma Registry at DOH will permit the following:

- Regular reporting to the public on the incidence and types of injury trauma suffered by residents;

- Development of epidemiological studies regarding the nature and origin of the various types of trauma injuries; and

- Provision of information on trauma injuries upon which the strategic planning of emergency response mechanisms can be based.

STRATEGY:

- Collaborate with the Injury Program in working towards the establishment of the Trauma Registry.

- Arrange for the Center for Prehospital Pediatrics, a part of Children's National Medical Center, to be the contractor on this project.

- As the first step in obtaining this goal, reactivate the Advisory Trauma Subcommittee for the establishment of the Trauma Registry.

- As the second step, conduct an assessment of current trauma systems by DOH with assistance from the Trauma Subcommittee.

RESOURCE REQUIREMENTS:

The Health Resources and Services Administration (HRSA) is providing funding the EHMSA to assist in the development of a Trauma Registry.

DECEMBER 2004 TARGET: By December 2004, the SWOT Analysis will have been completed.

2) **2010 Goal 7-6:** An Enforcement Division has been fully staffed and is in place in the DOH EHMSA.

Objective 7-6: Establish an Enforcement Division within the DOH EHMSA to ensure compliance with the DOH specified EHMSA rules and regulations.

Baseline: In 2002, an Enforcement Division was established at EHMSA. The new division is "up and running" and has been staffed since January or February of 2003.

Recommended Action:

The Enforcement Division will require staff that is trained to issue citations for noncompliance with the DOH specified EHMSA rules and regulations.

Rationale:

In its capacity as the certifying agency, EHMSA requires an Enforcement Division to ensure compliance with its rules and regulations.

Strategy:

- Train staff in the Cross-Agency Enforcement Certification procedures by the Office of the City Administrator.

- Develop a Manual of Procedures for Enforcement Practices.

Resource Requirements:

- Continued funding of staff positions.

December 2004 Target: By December 2004, the Manual of Procedures has been developed and implemented.

3) **2010 Goal 7- 8:** A DNR Registry has been established at the DOH EHMSA.

Objective 7-8: Establish a Do Not Resuscitate (DNR) .Registry at the DOH EHMSA.

Baseline 7-8: A DNR Registry had not yet been established as of April of 2003.

RECOMMENDED ACTION:

The DNR Regulations were drafted by EHMSA with the support of the Partnership for End of Life Care Group and passed by the DC City Council without funding in 2001.

RATIONALE:

Inspite of the lack of funding, a training in DNR practices was conducted for EMS providers under EHMSA with the support of the Partnership for End of Life Care.

STRATEGY:

- Allocate funding for the staffing of a position of coordinator of DNR activities,

- Provide training for staff of Nursing Homes, Hospices, private physicians, and EMS personnel in DNR Best Practices.

RESOURCES REQUIRED:

- Funding for the position of DNR activities coordinator
- Funding for supplies and equipment

DECEMBER 2004 TARGET: By December 2004, the DNR Registry is up and running and staffed.

Focus Area: Health Care Finance

Access to health care is a leading health indicator.

1) **2010 Goal 8-3:** Comprehensive Data Reporting System will be established that will yield accurate, timely data for Health Care Financing decision making.

Objective 8-3: Establish a comprehensive data reporting system to monitor the utilization of services and quality outcomes by contracted health plan, enrolled populations and provider types.

Baseline 8-3: (Developmental): A twenty-plus year old Medicaid Management Information System (MMIS) was replaced in July 2002 with an updated claims adjudication system for the Medicaid program. Although this greatly improves the operation of the claims payment and related production systems, there is also no current, separate analytical system for analyzing the data from the current MMIS. A needed additional component is a separate analytic engine that will take periodic production system data and allow analyses that will improve the management and policy development functions of the agency.

RECOMMENDED ACTION:

- Ensure that the implementation plan proceeds as scheduled for the post-transfer activities of the new system through using periodic status reports from the fiscal intermediary and using the monitoring contractor to review all MMIS post-implementation activities.

- Based on the assessment findings of a separate Health Insurance Portability and Accountability Act (HIPAA) assessment that was completed in 2002, complete the remediation of the MMIS by October 2003.

RATIONALE:

- The strategic role of Medicaid in the financing of services to vulnerable, uninsured populations is central to ensuring the overall health of all District residents.

- To measure the impact and success of Medicaid's various programs and populations, will take a more sophisticated system for the collection and manipulation of Medicaid data.

- The Medicaid Data warehouse will fulfill this need.

Strategy:

- MAA is collaborating with the State Center for Health Statistics Administration (SCHSA) on the development of an Expanded Medicaid Data Warehouse concept for decision support in MAA.

- The Phase I Activity(vendor deliverables) will take place between July 2003 – November 2003 and will include the following steps:
  - Review the best practices in Medicaid data warehousing around the country and
  - Synthesize these best practices in a draft for an Advanced Planning Document that will be submitted to the Centers for Medicare and Medicaid (CMS) for funding the development of the actual data warehouse in 2004;

- Timelines for 2003-2004:
  - In December 2003, a preliminary draft will be prepared by the vendor for MAA's review.
  - In first quarter of 2004, review process for preliminary draft – informal submission to CMS
  - By the end of the first quarter, with the approval of CMS, a contract will be let for bidding through GSA.

RESOURCE REQUIREMENTS:

- Information on staff hardware and software requirements in the MMIS contract
- Updated reporting requirements from end-users.
- Synthesized best practices and functionality design for APD documents.

DECEMBER 2004 TARGET: By December 2004, a data warehouse will be established.

2) **2010 GOAL 8-4:** Temporary Assistance to Needy Families **(**TANF)-related enrollees have a specified source for on-going primary care.

OBJECTIVE 8-4: Increase to 95% the proportion of all TANF-related enrollees who have a specified source of ongoing primary care (i.e., a medical/health home).

BASELINE 8-4: In 1998 approximately 87% of all TANF enrollees had a specified source of on-going primary care (e.g., being enrolled in one of the MAA-contracted managed care organizations (MCOs)).

This goal was met in 2002.

3) **2010 GOAL 8-7:** Medicaid-eligible persons will have access to comprehensive behavioral health services (i.e., mental health and substance abuse services).

OBJECTIVE 8-7: Collaborate in the creation of an integrated services delivery system which assures that Medicaid eligible persons have access to comprehensive behavioral health services, including mental health and substance abuse services.

BASELINE 8-7: (Developmental). There was not an integrated system of care for both mental health and substance abuse services as of 2003. MAA has previously implemented Mental Health Rehabilitation Option Services and has submitted a State Plan Amendment for Substance Abuse Rehabilitation Option Services in the summer of 2003. These two services will provide the platform for a behavioral health system for Medicaid recipients where services will be coordinated between Medicaid managed care and the fee-for-service system.

RECOMMENDED ACTION:

Develop an infrastructure within APRA for billing the individual provider agencies under its authority for substance abuse services rendered under the Medicaid Rehabilitation Option (MRO) proceeding as follows:

- Work with the Department of Health and APRA to develop a new State Plan Amendment (SPA) for Medicaid Rehabilitation Option (MRO) services for substance abuse treatment for submission to the Council of the District of Columbia ("Council") for approval (completed this summer).

- When approved by City Council, submit SPA to the Centers for Medicaid and Medicare Services (CMS) for review and approval by or before the end of this calendar year (submitted to CMS).

- After the approval of the SPA for MRO substance abuse treatment services by CMS, work with APRA on its development of the infrastructure at APRA for an integrated services delivery system for billing the individual provider agencies under its authority.

RATIONALE:

Medicaid coverage for substance abuse treatment MRO services is a priority in 2003, because it is not cost-effective to provide fragmented care to persons needing behavioral health services.

- The Managed Care contract signed in August 2002 with the four managed care organizations (MCO) that are contracted providers includes basic mental health services as part of the managed care benefits package.

- CMS has approved the SPA for mental health MRO services that provides for the delivery (by DMH Core Service Agencies) of more complex mental health services for those enrollees with more severe and chronic mental illnesses.

- There are on-going efforts to coordinate the mental health services for enrollees, so that whether they need the basic services within the MCOs or the more complex services outside of the MCO, they can receive the appropriate services in the suitable setting.

- A formal agreement will be established between MAA and APRA that is supported by an approved SPA by the end of 2004.

STRATEGY:

- Develop SPAs for a set of behavioral health services in the mental health and substance abuse areas; (done)

- Develop appropriate rates, standards and criteria for services review. (done)

- Establish a formal agreement between MAA and APRA for integrated MRO services that is supported by an approved SPA.

- Develop coordination of behavioral health services provided among Medicaid MCOs, DMH and APRA, particularly for those persons who are dually diagnosed with both substance abuse and mental health diagnoses.

RESOURCE REQUIREMENTS:

- CMS Approval of Substance Abuse Treatment SPA for MRO services;
- CMS approval of proposed rates; and
- Standards and criteria development for dually diagnosed persons.

DECEMBER 2004 TARGET: By December 2004, MAA has participated in the development of coordinated behavioral health system of care that includes services provided across MCOs, DMH providers, and APRA providers for Medicaid recipients having either a mental health or a substance abuse diagnosis or both (dually diagnosed).

Focus Area: Maternal, Infant and Child Health and Family Planning

Responsible Sexual Behavior is a Leading Health Indicator.

1) **2010 GOAL 9-1:** The infant mortality rate has been reduced to no more than 8 per 1,000 live births.

OBJECTIVE 9-1: Reduce the infant mortality rate to no more than 8 deaths per 1,000 live births.

BASELINE 9-1: The infant mortality rate was 10.6 per 1,000 live births in 2001.

RECOMMENDED ACTION:

- Early and frequent prenatal care must be obtained. Programs must increase their outreach capacity and take the initiative to find and educate women about the importance of care.
- In addition, programs must forge strong referral relationships between prenatal services and other programs that are in touch with potential clients. An example of this is with the WIC Program.
- The Institute of Medicine (IOM) recommends reducing the risk before conception. This can be achieved by providing pre-pregnancy counseling, stressing a healthier woman and the importance of having and maintaining a healthy lifestyle prior to pregnancy.

RATIONALE:

- Infant mortality is a marker for the overall health of a community.
- Between 1992 and 2001, the infant mortality rate has dropped by 42.1% in the District of Columbia.
- However, great disparities still exist between racial and ethnic groups in this area.
- In addition, great disparities exist between racial and ethnic groups in this area.

STRATEGY:

- Increase outreach activities to identify at risk pregnant women and infants. This includes working with internal and external agencies such as WIC and non-profit organizations;

- Continue aggressive home visiting to ensure pregnant women and infants receive care and expand the 48-hour Newborn Home Visiting Initiative;

- Work with Medicaid and other health care providers to ensure everyone is taking a proactive approach to reducing infant mortality and Improving health outcomes by stressing changing attitudes; and

- Promote lifelong healthy lifestyle practices and behaviors.

RESOURCE REQUIREMENTS:

- Additional local dollars to fully fund the Newborn Home Visiting Initiative, and
- Coordination with other home visiting programs throughout the city in order to avoid duplication of effort and leverage available resources.

DECEMBER 2004 TARGET:

As of December, 2004, the infant mortality rate will have been decreased from 10.6 in 2001 to 10.0 per 1,000 live births.

2) **2010 GOAL 9-6:** The proportion of all pregnant women who begin prenatal care in the first trimester is increased to 80%.

OBJECTIVE 9-6: Increase to at least 80% the proportion of all pregnant women who begin prenatal care in the first trimester of pregnancy.

BASELINE 9-6: In 2001, 74.4% of all District of Columbia resident births were to women who began prenatal care in the first trimester.

RECOMMENDED ACTION:

- Early and frequent prenatal care must be obtained. Research has shown that the chance of a woman having a healthy birth outcome is increased the earlier she obtains prenatal care.

- Programs must increase their outreach capacity and take the initiative to find and educate women about the importance of care.

- Programs targeted at getting high-risk, hard-to-reach women into prenatal care early should be culturally sensitive.

RATIONALE:

- Several barriers to accessing prenatal care have been identified through the years. These include inadequate transportation and childcare services, the systemic inadequacy in recruiting hard-to-reach women, and the lack of insurance to pay for prenatal care.

- Other factors have also contributed to women not obtaining care early, including lack of information about the importance of early care and dissatisfaction with health care providers.

- In addition, great disparities exist between racial and ethnic groups, with African American women being least likely to obtain care in the first trimester when compared to their white counterparts.

STRATEGY:

- Increase outreach activities to identify women who are pregnant early in their pregnancy and encourage entry into prenatal care.

- Launch intensive public information campaign that stresses the importance of early entry into prenatal care.

- Work with medical providers to alleviate access issues for pregnant women.

- Encourage maximum use of the Medicaid program (for pregnant women).

- Improve reporting of entry into prenatal care on the birth certificate.

RESOURCE REQUIREMENTS:

- Additional funds to conduct a comprehensive and coordinated public information campaign.
- Coordinate current resources (funding, personnel, etc.) throughout the city to conduct extensive outreach activities focused on identifying pregnant women and getting them into care early.

DECEMBER 2004 TARGET:

As of December 2004, 75% of all District of Columbia resident births are to women who began prenatal care in the first trimester

Focus Area: Public Health Infrastructure

1) **2010 GOAL 10-3:** Data on the health status, as well as demographic and socioeconomic status of residents are accessible at the SCHSA for all of the resident population groups in the District of Columbia.

OBJECTIVE 10-3: Develop data on the health status, as well as demographic and socioeconomic status of all racial/ ethnic population groups residing in the District (Black, white, Hispanic /Latino, Asian American/ Pacific Islander, American Indian/Alaska Native). Included should be definitive health status data on all resident populations and select population subgroups that reflect minority health disparities.

BASELINE 10-3: Vital Records data on all five population groups have been available since 1989. As of January 2003, data on three of the five resident population groups (Black, White, Hispanic) are available in reports routinely produced by the SCHSA. As of 2003, no data on health status are routinely collected for all five resident population groups.

RECOMMENDED ACTION:

Recognizing the need for greater consistency in tracking population group, the developers of the federal Healthy People 2010 Plan, adopted a minimum template for all Healthy People 2010 population-based objectives. The minimum template for all population-based objectives is as follows:

Race:
- American Indian or Alaska Native
- Asian or Pacific Islander:
  - Asian
  - Native Hawaiian or Other Pacific Islander
- Black or African American
- White

Ethnic origin:
- Hispanic or Latino

Gender:
- Female
- Male

Socioeconomic status:

Family income level	Education level
Poor	Less than high school
Near poor	High school graduate
Middle/ high income	At least some college.

RATIONALE:

- Provision of demographic, socioeconomic and health status data for all population groups is essential for the monitoring of health status to identify community health

problems and the diagnosis and study of health problems and hazards in the community, both of which are essential public health services.

- Databases on each of the racial and/or ethnic population groups residing in the District are essential for the identification and tracking of health disparities and of any progress made in the elimination of disparities. These databases should include definitive data that reflect the health disparities experienced by each of the minority population groups or subgroups.

- The December 2002 target has been attained. For Vital Records data, target attainment is about 90 percent. Natality and mortality data are about 90 percent complete for year 2002 by the five racial and ethnic population groups. Mortality data include education levels and employment status. Natality data include education levels of parent, but not employment. Information on insurance status is not included in Vital Records data.

- The routine inclusion of birth and death data from all of the resident population groups is the first step in building a minority health database for the District. To monitor health disparities, additional health status data on all resident population groups and representative subgroups will be included for tracking purposes.

STRATEGY:

- Sustain the most successful strategy in maintaining birth records with complete demographic and SES information which is the electronic submission of natality data by hospitals to the SCHSA Vital Records Division, a process that ensures the completeness of data submissions for births. In Vital Records, birth data are coded and sent to the Research and Analysis Division for key entering or data reduction and electronic submission to OIS (Office of Information Systems).

- Conduct a community health status assessment that captures definite data on all resident population groups and selected subgroups.

- Establish a network of community assessment supporting community-based organizations (CBOs) that serve as gateways to the minority residential communities and share the goal of an all inclusive residential health status determination to measure progress in eliminating disparities.

- Establish partnerships for technical expertise with key, as well as university-based researchers to determine the assessment process to be followed, survey design and development of the survey instruments,

- Establish partnership with university researchers for training and implementation of the survey.

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- Conduct the assessment for analysis at a developing research center for resident minority health data at the SCHSA in collaboration with the technical advisory board.

- Formally designate and promote the minority health data research center at SCHSA

RESOURCE REQUIREMENTS:

- Adequate funding for the community health assessment.
- Effective partnerships sustaining the coalition of supporting CBOs
- Effective partners on the Technical Advisory Board.
- Support of DOH colleagues and administrators.

December 2004 Target: By December 2004, baseline data on the health status of Latinos will be on file at the SCHSA.

2) **2010 Goal 10-1**: 90% of DOH agencies provide onsite access to data via electronic systems and online information systems.

Objective 10-1.1: Increase to 90% the proportion of DOH agencies that provide onsite access to data via electronic systems and online information systems such as the Internet.

Baseline 10-1.1: Zero in 1997. DOH agencies had no access to the internet at this time. By 2001, this goal had been met. All of the major sites at DOH – around 1200 employees - are connected via electronic systems and online information systems and have internet access.

RECOMMENDED ACTION:

- This objective was a direct application of the federal *Healthy People 2010 objective 23-1:* Increase the proportion of Tribal, State, and local public health agencies that provide Internet and e-mail access for at least 75% of their employees and that teach employees to use the Internet and other electronic information systems to apply data and information to public health practice.

PROGRESS IN TARGET ATTAINMENT:

This goal has already been attained and surpassed. As of July, 2001, 100% of DOH agencies have onsite access to data via electronic systems and online information systems.

3) **2010 Goal 10-1.2:** DOH has a departmental intranet.

Objective 10-1.2: Develop and implement a departmental intranet for the DOH.

Baseline: Components of the departmental intranet for DOH were 10% complete in 2001.

RECOMMENDATION. This objective is an extension of the federal 2010 Objective 23-1.

RATIONALE: A departmental intranet is needed to improve communications and to serve as an information source for DOH offices, programs and staff.

STRATEGY:

- Develop guidelines and requirements for DOH Intranet.
- Also, work with the Office of the Chief Technology Officer (OCTO) regarding development of citywide standards and support for implementation.

RESOURCE REQUIREMENTS:

DECEMBER 2004 TARGET: As of December 2004: work on the DOH intranet will be 50% complete.

4) **2010 Goal 10-1.3:** Wireless communication capability for Bioterrorism preparedness and other communications requirements is in place.

Objective 10-1.3: Implement wireless communication capability for Bioterrorism preparedness and other communications requirements.

Baseline: The process was begun in 1997, and about 40% of the planned components have been installed as of 2003.

RECOMMENDATION: This objective is an extension of the federal 2010 Objective 23-1.

RATIONALE:

- Wireless communications are extremely important to help assure communications during a Bioterrorism threat (BT) or other critical event.
- Staff must have use of and access to wireless devices, such as pagers and personal digital assistant (PDA), to communicate in the event of an emergency.

STRATEGY:

- Continue to define business needs and requirements for wireless communications.

RESOURCE REQUIREMENTS: Purchase wireless devices and service.

DECEMBER 2004 TARGET: As of December 2004, 50% of work to be completed.

5) **2010 Goal 10-5**: Use of geocoding in all DOH data systems to promote the development of Geographic Information Systems (GIS) capabilities has been increased to 50 percent.

Objective 10-5: Increase to 50% the use of geocoding in all DOH data systems to promote the development of Geographic Information Systems (GIS) capabilities.

Baseline: 10-5: About 10% of DOH agencies were using GIS in 1997.

RECOMMENDED ACTION:

- Phase I Implementation (2003-2004)
  DOH will acquire the initial GIS hardware and software to create a core system capable of supporting basic GIS functions. Selected staff will receive general training in the GIS software to support the initial implementation effort. Selected high priority custom applications will be developed that demonstrate the utility of GIS and clearly show its benefits and potential. Custom applications developed in Phase I are also aimed at building a foundation of GIS related services that can be leveraged by subsequent applications. High priority DOH data layers will be identified, converted as required and migrated into the system to support the applications.

RATIONALE:

- Geographic Information Systems (GIS) in Public Health encompasses the design, development and utilization of GIS tools for the description of health situations, epidemiological analysis and public health management.

- The abilities of GIS to integrate and process data contribute to its potential for application in different areas of public health.

- Some of the main application areas of GIS in health are: the spatial distribution of a health event; the identification of environmental and occupational risks; health situation analysis in a geographic area; identification of high risk groups and critical areas; public health surveillance and monitoring; the generation of research hypothesis; and the planning, programming and management of health activities.

- Thus, GIS offers enormous potential for improving health services and assisting in eliminating health disparities. DOH programs are encouraged to employ GIS by organizing, using and distributing spatial information and thereby making the achievement of the Healthy People 2010 goals more realistic.

STRATEGY:

Phase I:

In order to ensure the coherence and success of system implementation, a comprehensive implementation management structure should be established and approved at the outset of implementation work for all three implementation phases. The foundation of the management structure should be a Project Management Plan that includes a work plan and schedule that reflects and details this implementation plan. The work plan should include the identification of tasks, responsibilities, project deliverables, and project milestones.

In addition to the Project Management Plan, plans for managing the various technical processes involved in software development should be prepared and approved, including a release management plan to structure and manage the incremental development of the recommended applications software, a configuration management plan to protect the functional integrity of the overall system, and a Quality Assurance Plan to ensure that the system achieves its objectives and meets industry standards.

The organizational support structure for the DOH GIS should provide the personnel framework required to make policy pertaining to the GIS, coordinate the technical needs and objectives and the GIS users, and operate the system itself.

Phase I training should be structured to address the needs of all personnel managing, operating, and using the DOH GIS at that point. The training needs will vary depending on the responsibilities or involvement of the trainee. The basic approach should be to train GIS administrators and technical personnel at the outset so that they can follow implementation work based on full understanding of their relationship to the system. Also at the outset, DOH should assign selected DOH personnel the role of training end users in the various Divisions, and those DOH trainers should be trained with a functioning Phase I system in place.

One of the principal recommendations of the Conceptual System Design Report is to develop a shared geodatabase for common-use data sets along with local division-maintained geodatabases for data that need not be shared or cannot be shared due to security constraints.

The central hardware necessary to support Phase I implementation should be acquired and configured in coordination with central software installation and core

database creation. The acquired hardware will be integrated with existing DOH IT hardware and networking resources for the purposes of the DOH GIS.

RESOURCE REQUIREMENTS:

The Phase I GIS support hardware that should be acquired are as follows: ArcSDE Data Server and Associated Data Storage Device; ArcIMS Intranet Servers (Internal and External); Windows Terminal Servers; Internet Web Server.

The GIS software that has been selected by DOH to provide the core functionality of the DOH GIS has been developed and is available commercially from ESRI. The basic ESRI COTS software that is required to support the anticipated Phase I DOH GIS activity is as follows: ArcSDE – One ArcSDE double CPU license is required to support Phase I functionality; ArcIMS – Two ArcIMS double CPU licenses are required to support Phase I functionality; ArcGIS – The following ArcGIS licenses are needed to support Phase I functionality; 2 ArcGIS ArcInfo Concurrent licenses, 5 ArcGIS ArcEditor Concurrent licenses, 20 ArcGIS Arc View Concurrent licenses, 2ArcGIS Spatial Analyst licenses, 2 ArcGIS Geostatistical Analyst licenses, 5 ArcGIS Publisher licenses, 5 ArcGIS ArcPress licenses.

Phase I implementation team members who should be put in place at the outset of Implementation work are as follows: One GIS Manager/Coordinator; One GIS System Administrator; One GIS Data Administrator.

DECEMBER 2004 TARGET: By December 2004, the first year of the GIS Phase I Implementation Plan will be completed with the intended completion of the building of GEO-Health Portal and the designing of the Geo-database Model. Phase I hardware and software will be acquired and installed. The supporting committees and organizational support structure should be in place.

PREVENT AND REDUCE DISEASES AND DISORDERS

11. ASTHMA
12. CANCER
13. DIABETES
14. DISABILITIES
15. CARDIOVASCULAR DISEASE
16. HIV/ AIDS
17. IMMUNIZATION
18. MENTAL HEALTH AND MENTAL DISORDERS
19. SEXUALLY TRANSMITTED DISEASES
20. SUBSTANCE ABUSE
21. TUBERCULOSIS

Focus Area: Asthma

1) **2010 Goal 11-1:** Asthma death rate is reduced to no more than 1.5 per 100,000 residents.

Objective 11-1: Reduce the asthma death rate to no more than 1.5 per 100,000 residents.

Baseline 11-1: The asthma death rate was 2.8 per 100,000 residents for all ages in 1997. The rate for 1998 was 3.8 per 100,000; in 1999 the rate was 2.1 per 100,000 and in 2000 the rate was 1.7 per 100,000.

Recommended Action:

Establish an Asthma Mortality Review Committee to examine case-by-case deaths related to asthma. Develop and implement appropriate intervention strategies.

Rationale:

- The asthma mortality rate is highest for those over 55 years of age. This high rate may be attributed to asthma, as well as other health factors.

- Currently there is no in-depth review of asthma-related deaths in the District. The creation of such a committee would serve to examine causes related to asthma deaths and develop appropriate intervention strategies and recommendations.

Strategy:

- Convene a panel of experts within the Department of Health to investigate asthma-related deaths, determine preventable causes, and make appropriate recommendations.

- Develop appropriate interventions to reduce the mortality in the high-risk populations.

Resource Requirements:

- Strong partnerships with community-based organizations, health systems, and primary care providers;
- Continued funding for current program personnel; and
- Continued funding from the Centers for Disease Control and Prevention for essential staff and implementation of proposed intervention outlined in the Department of Health document “a Strategic Plan to Reduce Asthma in the District of Columbia;”
- Continued funding from the Title V Block grant to leverage the CDC grant and provide critical in-kind staff support for current program operations;
- Identification of resources within the tobacco settlement fund designated in the FY’o5 Budget for Asthma Program implementation.

DECEMBER 2004 TARGET: By December, 2004, the asthma death rate has decreased by.1 per 100,000 residents per year for all ages.

2) **2010 Goal 11-2:** The overall asthma morbidity rate is reduced to 10 per 10,000 residents.

Objective 11-2: Reduce the overall asthma morbidity rate, as measured by a reduction in the asthma hospitalization rate, to 10 per 10,000 residents.

Baseline 11-2: The hospitalization rate in 1998 was 27 per 10,000; in 1999 31 per 10,000; in 2000, 22 per 10,000; and in 2001 13 per 10,000 residents (using 2000 population).

Recommended Action:

- Promote the use of National Guidelines for asthma diagnosis and treatment;
- Increase by 20% annually the number of providers that adhere to the National Guidelines for asthma diagnosis and treatment;
- Increase by 20% annually the number of primary care providers educated on effective asthma counseling;
- Increase by 10% the educational outreach programs for all at-risk populations, especially for pediatric and geriatric groups through the DC Control Asthma Now (DC CAN) Asthma Education Program; and
- Promote the utilization of effective asthma management plans.

Rationale:

- The use of standard guidelines and asthma management plans will increase continuity of care and improve health outcomes of asthmatics.
- The increasing number of primary care providers educated on effective asthma counseling will reduce asthma hospitalizations by increasing the number of patients who can effectively manage their own asthma.
- The increase in self-management knowledge of geriatric patients and pediatric asthmatic caregivers will reduce the number of asthma hospitalizations. The highest hospitalization rate is among children 0-4 and adults over 55 years of age.

Strategy:

- To partner with various medical facilities, associations and providers to promote the use of National Guidelines for the diagnosis and treatment of asthma;

- To educate a minimum of 100 providers per year for the next five years on the Physician Asthma Care Education Program or other evidence-based educational interventions for providers; and

- To develop and implement community-based asthma health education intervention programs for target population.

Resource Requirements:

- Strong partnerships with community-based organizations, health systems, and primary care providers;
- Continued funding for current program personnel; and
- Continued funding from the Centers for Disease Control and Prevention to implement proposed strategies.

December 2004 Target: By December 2004, the asthma hospitalization rate has decreased by 1 per 10,000 residents per year for all ages.

3) **2010 Goal 11-3:** The asthma morbidity rate is reduced to no more than 46 per 10,000 population. This rate may be adjusted once baseline data are established.

Objective 11-3: Reduce the asthma morbidity rate, as measured by a reduction in the annual rate of Emergency Department visits, to no more than 46 per 10,000 population. This rate may be adjusted once the baseline data are determined.

Baseline 11-3: Emergency Department baseline data are to be added.

Recommended Action:

- Identify and eliminate barriers and gaps in the delivery of asthma care services, particularly in the underserved communities, through a collaborative effort of government and private agencies;

- Increase by 10% annually the number of asthma awareness/ education programs that are culturally sensitive and linguistically appropriate for asthmatics and caregivers of all races and socioeconomic status;

- Increase by 10% annually the number of asthma counseling programs to improve asthma management skill of pediatric caregivers; and

- Support an increase of 10% in the number of DC Public School nurses and essential non-medical personnel trained in effective asthma management technique.

RATIONALE:

Science-based education programs for caregivers can help decrease Emergency Department visits. Caregivers of pediatric asthmatics are more likely to use the services of the Emergency Department to manage severe asthma attacks.

Strategy:

Work with various community agencies to develop health promotion and health education programs that are relevant to the constituencies that they serve.

Resource Requirements:

- Strong partnership with DC Public School Administration;
- Strong partnership with community-based organizations, health systems, and primary care providers;
- Continued funding for current program personnel; and
- Continued funding from the Centers for Disease Control and Prevention to implement proposed strategies.

December 2004 Target: By December 2004 the Emergency Department visit rate has decreased by 10 per 100,000 residents per year for all ages.

Focus Area: Cancer

Lung Cancer

1) 2010 Goal 12-1: Mortality from lung cancer in the District of Columbia has been reduced to an age-adjusted rate of 40.2 per 100,000 residents.

Objective 12-1: Reduce lung cancer mortality in the District of Columbia to an age-adjusted rate of no more than 40.2 per 100,000 residents.

Baseline 12-1: The age-adjusted lung cancer death rate in the District in 1997 was 46.7 per 100,000 residents.

RECOMMENDED ACTION:

- Increase smoking cessation and reduction education and programs targeted to youth and addicted young adults.
- Encourage and educate providers to reinforce smoking cessation and offer cessation tool, especially to Hispanic and African-American, young adults

RATIONALE:

- Lung cancer is the most common cause of cancer death among both females and males in the United States.
- It is the leading cause of cancer deaths in the District of Columbia.
- Tobacco use is the single most preventable cause of death in the society and is the most important risk factor for lung cancer in the District.
- After 10 years of abstinence, smoking cessation decreases the risk of lung cancer to 30 to 50 percent% of that of continuing smokers.

STRATEGY:

- Increase the number of smoking cessation programs offered in the District of Columbia. (This strategy was successfully implemented in 2002.)
- Increase the number of smoking cessation programs available to Spanish speaking residents. (This strategy was successfully implemented in 2002.)
- Expand the availability of smoking cessation tools (patch, pills, gum) free of charge to residents requesting smoking cessation aids. (This strategy was less successful in 2002.)

- Provide improved quit line information on cessation assistance for residents requesting help for smoking cessation. (This strategy was less successful in 2002.)

- Increase number of primary care providers who assist and incorporate smoking cessation messages in routine patient encounters. (This strategy was less successful in 2002.)

- Increase availability of smoking cessation and anti-tobacco materials available in provider offices. (This strategy was less successful in 2002.)

RESOURCE REQUIREMENTS:

District and grant funding for cessation tools, quit line maintenance, and brochure development and distribution.

DECEMBER 2004 TARGET: By December 2004, at least one smoking cessation class will be available in each ward of the city with a variety of cessation tools provided to those who require them. Approximately 80% of this target was attained in 2002.

Breast Cancer

1) **2010 Goal 12-2.1:** Breast cancer mortality in the District has been reduced to an age-adjusted rate of no more than 24.4 per 100,000 residents.

Objective 12-2.1: Reduce the age-adjusted mortality rate for female breast cancer in the District of Columbia to no more than 24.4 per 100,000 residents.

Baseline 12-2.1: The age-adjusted mortality rate for female breast cancer in the District in 2000 was 27.0 per 100,000 residents.

RECOMMENDED ACTION:

- Early cancer detection saves lives by identifying tumors at an early stage of disease development when treatment is more effective and prognosis is most favorable.

- To detect breast cancer early, the American Medical Association recommends a clinical breast exam every three years for women 20- 39 years in age.

- Annual clinical breast examinations and mammograms are recommended for women 40 years of age and over.

- Uninsured or underinsured women need assistance in obtaining these early cancer detection services.

RATIONALE:

- Clinical breast exams and mammograms can detect cancer early and reduce mortality.

- Approximately 36,000 women are uninsured or underinsured in the District.

- Of these women, 13,000 are in the 40 – 64 years age range and in need of annual mammograms and clinical breast exams.

STRATEGY:

- In 2003, provide breast cancer education, through multi-media campaigns, one-on-one outreach, and group teachings, to at least 15,000 women in the District of Columbia. (One of the most successful strategies in 2002.)

- Provide free breast cancer screening and follow-up to at least 1500 uninsured or underinsured District women.

- Provide outreach to priority populations, including African-Americans, Hispanics, Asian/Pacific Islanders, lesbians, and women with disabilities.
  - Utilize mass mailings twice per year to distribute educations information. (This was the least successful strategy in 2002.)
  - Collaborate with television and radio stations to provide PSAs once per year. (This was one of the most successful strategies in 2002.)
  - Utilize metro rail and bus advertisement space to raise awareness about breast cancer once per year.
  - Utilize Peer Volunteer Program monthly to provide one-on-one outreach. (This was one of the most successful strategies in 2002.)
  - Conduct group education sessions monthly.
  - Collaborate with Project WISH network providers to ensure free screenings at over 40 contracted, local sites.

RESOURCE REQUIREMENTS:

- Funding from the federal Centers for Disease Prevention and Control (CDC) and the District government for health education, screening, and follow-up.

December 2003 TARGET: As of December 2004, (1) at least 15,000 District women will receive breast cancer education and (2) 1,500 uninsured and underinsured District women will receive free breast cancer detection services. This is a repeat of last year's target which was 100% attained.

Cervical Cancer

2) **2010 Goal 12-2.2:** Cervical cancer mortality in the District has been reduced to an age-adjusted rate of no more than 0.88 per 100,000 residents.

Objective 12-2.2: Decrease the age-adjusted mortality rate of cervical cancer deaths to no more than 0.88 per 100,000 residents

Baseline 12-2.2: The age-adjusted cervical cancer mortality rate in the District in 2000 was 4.3 per 100,000 residents.

RECOMMENDED ACTION:

- The American Medical Association recommends that all women who are or who have been sexually active, or who have reached the age of 18, should have an annual Pap test and pelvic exam.
- After a woman has had three or more consecutive, satisfactory, normal annual exams, the Pap test may be performed less frequently at the discretion of a clinician.
- Uninsured or underinsured women need assistance in obtaining early cancer detection services.

RATIONALE:

- Cervical cancer mortality rates in the US have declined over 40% since the1970s, in large part because of widespread use of the Pap test.
- The Pap test has reduced death rates by identifying cancerous and pre-cancerous cervical cells.
- Half of all women with newly diagnosed invasive cancer have not had a Pap test in the last five years.
- Approximately 36,000 District women are uninsured or underinsured and in need of a Pap test and pelvic exam.

STRATEGY:

- In 2003, provide cervical cancer education, through multi-media campaigns, one-on-one outreach, and group teachings, to at least 15,000 District women.
- Provide free Pap tests and pelvic exams to at least 1,700 uninsured or underinsured District women in over 40 provider sites.

- Priority populations to be reached include African-Americans, Hispanics, Asian/Pacific Islanders, lesbians, and women with disabilities.
  - Utilize mass mailings twice per year to distribute educational information. (This was the least successful strategy in 2002.)
  - Collaborate with radio stations to provide PSAs once per year. (This was one of the most successful strategies in 2002.)
  - Utilize metro rail and bus advertisement space to raise awareness about cervical cancer once per year.
  - Utilize Peer Volunteer Program monthly to provide one-on-one outreach. (This was one of the most successful strategies in 2002.)
  - Conduct group education sessions monthly.
  - Collaborate with Project WISH network providers to ensure free screenings at over 40 contracted, local sites.

RESOURCE REQUIREMENTS:

CDC and District funding for health education, screening, and follow-up.

DECEMBER 2004 TARGET: By December 2004, (1) at least 15,000 District women will have received cervical cancer education, and 1,700 uninsured or underinsured District women will receive free cervical cancer detection services.

PROSTATE CANCER

1) **2010 Goal 12-4 :** The prostate cancer mortality rate for African American men has been reduced to an age-adjusted 24.4 per 100,000 residents.

Objective 12-4: Reduce the prostate cancer mortality rate for African American men to no more than 24.4 per 100,000 residents.

Baseline 12-4: The overall prostate cancer mortality rate was 27.8 per 100,000 in 1997. In African American men in 2002, the rate was reduced from 32.9 to 29.0 per 100,000 residents.

Recommended Action:

- Increase the level of awareness and knowledge of the disease among African American men, as well as

- Their access to detection, diagnostic, and treatment services, especially those men without health insurance.

Rationale:

Mortality rates are more likely to decline, if prostate screening rates for African American men significantly increase, in response to:

- Increased understanding of their high risk status and the importance of seeking early detection, and
- The removal of financial/geographic barriers to clinical services.

Strategy:

- Re-establish the community-based education and screening program in those wards that have the highest incidence and mortality rates for prostate cancer (Wards 4,5,6,7/8).
- Increase the level of health communications to the public citywide. (This was one of the most successful strategies in 2002.)
- Establish partnerships with organizations or groups that have routine access to men, especially African-American men.
- Integrate the program with other chronic disease risk reduction efforts.
- Establish a faith-based education and awareness initiative.
- Institute a follow-up/case management system for all abnormal screening findings, especially for uninsured men.
- Increase the use of "Project Orion" mobile health screening van to reach men within their own communities.

Resource Requirements:

- Funding for core program staff.
- Funding to continue and expand contractual, community-education, early detection, and case management.

DECEMBER 2004 TARGET: By December 2004, the prostate cancer mortality rate for African American residents will have been stabilized at 24.4 per 100,000.

2010 GOAL: DISEASE SURVEILLANCE – CANCER REGISTRY

The District of Columbia Cancer Registry is a population-based cancer surveillance system that maintains a record of the occurrence of all malignant cancer cases among District residents.

In conformity with the national *Healthy People 2010* goal, the DC Cancer Surveillance System aims to provide data to monitor efforts to reduce the number of new cancer cases as well as the illness, disability, and death attributable to cancer.

1) **2010 Goal 12-5.1** (National 3.14): A statewide population-based cancer registry has been established that captures information on at least 95% of the expected number of reportable cases.

Objective 12-5.1: Establish a statewide population-based cancer registry that captures information on at least 95% of the expected number of reportable cases.

Baseline 12-5.1: As of January 1998, 101.7% of the expected number of reportable cases are being captured.

RECOMMENDED ACTION:

- In its section on Cancer, the national *Healthy People 2010* editors describe cancer registries that provide accurate, complete, and timely data as a critical component of the public health infrastructure in the United States.

- The District will comply with the National Program of Cancer Registries (from CDC) requirements for a viable State Cancer Registry by: (a) developing legislation and regulations for enhanced registry operations, (b) meeting the standards of data quality, completeness and timeliness, and (c) providing training to registry personnel.

RATIONALE:

Data from the DOH Cancer Registry Surveillance System are critical for the following applications:

- As the foundation for a District-wide comprehensive strategy to reduce cancer morbidity and mortality;

- As an indispensable tool for health professionals in the research and analysis of the cancer burden imposed n residents; and

- As the basis for monitoring and evaluation of the clinical (screening and diagnostic and treatment), epidemiological and supportive health services provided residents diagnosed with cancer.

STRATEGY:

In order to ensure that at least 95% of the cases occurring in 2001 by the District of Columbia Cancer Registry Surveillance System are captured, the following strategies are needed:

- Contact all primary, secondary and out-of-state sources to access all cancers occurring during the 2001 calendar year;

- Conduct re-casefinding at all sources (primary and secondary) of cases diagnosed within the District of Columbia in 2000. (This was one of the most successful strategies in 2002.);

- Conduct comprehensive quality control protocols (including chart audits, death certificate follow-backs and training) to ensure data gathered in 2001 are of the highest quality (This too was one of the most successful strategies in 2002);

- Continue to enforce cancer reporting regulations to ensure confidentiality of cancer data, and the timely reporting of cancer information from District facilities (Use of the Advisory Committee as leverage to ensure hospital compliance with reporting regulations was one of the most successful strategies in 2002.);

- Submit data on cases diagnosed in 2001 for registry certification to CDC and the North American Association of Central Cancer Registries (NAACCR).

RESOURCE REQUIREMENTS:

The following resources are required for the implementation of the cancer surveillance systems:

- Local staff of one program manager, one computer programmer specialist, and four coding clerks.
- Contractual staff for the District of Columbia Cancer Registry Database Management;
- Computer (software and hardware) resources; and
- Local and CDC funding.

DECEMBER 2004 TARGET: By December 2004, capture information on at least 95 % of the expected number of reportable cases among District residents occurring during the 1991 calendar year. This target was 100% attained in 2002 and will be carried over into 2003.

2) **2010 Goal 12-5.2** Trends in the incidence of and death from lung cancer among residents are monitored by the DC Cancer Surveillance System using in the District's Cancer Registry.

Objective 12-5.2: Enable the DC Cancer Surveillance System to monitor trends in incidence and death rates of cases of overall cancers among residents using the District's Cancer Registry System.

Baseline:
12-5.2a: Incidence and death rates in lung cancer among residents captured by the Cancer Registry in 1997 were 62.4 and 46.7 per 100,000 population, respectively.

12-5.2b: Incidence and death rates in breast cancer cases among residents captured in 1997 were 139.6 and 29.1 per 100,000, respectively.

12-5.2c: Incidence and death rates in cervical cancer cases among residents captured in 1998 were 22.2 and 2.2 per 100,000, respectively.

12-5.2d: Incidence and death rates in colorectal cancer cases among residents captured in 1998 were 57.1 and 17.7 per 100,000, respectively.

12-5.2e: Incidence and death rates in prostate cancer cases among residents captured in 1998 were 202.0 and 27.8 per 100,000, respectively.

RECOMMENDED ACTION:

- In its section on Cancer, the national *Healthy People 2010* editors describe cancer registries that provide accurate, complete, and timely data as a critical component of the public health infrastructure in the United States.

- The District will comply with the National Program of Cancer Registries (from CDC) requirements for a viable State Cancer Registry by: (a) developing legislation and regulations for enhanced registry operations, (b) meeting the standards of data quality, completeness, and timeliness, and (c) providing training to registry personnel.

RATIONALE:

Monitoring trends in total cancers, and the seven leading cancer sites is required for cancer surveillance, for the following reasons:

- The seven sites are the ones most amenable to medical intervention and likely to have the greatest impact on cancer incidence and mortality rates;

- They account for nearly 66% of all incident cancers, and 55 percent of all cancer deaths in the District of Columbia.

STRATEGY:

In order to ensure that at least 95 % of the cases occurring in 2001 by the District of Columbia Cancer Registry Surveillance System are captured, the following strategies are needed:

- Contact all primary, secondary and out-of-state sources to access all cancers occurring during the 2000 calendar year (Our reciprocal exchange of data with the neighboring states was instrumental in ensuring the completeness of data.)

- Conduct re-casefinding at all sources (primary and secondary) of cases diagnosed within the District of Columbia in 2001;

- Conduct comprehensive quality control protocols (including chart audits, death certificate follow-backs and training) to ensure data gathered in 2001 are of the highest quality (Another of the most successful strategies was the use of electronic death certificate follow-back to identify all non-reported cases.);

- Continue to enforce cancer reporting regulations to ensure confidentiality of cancer data, and the timely reporting of cancer information from District facilities;

- Submit data on cases diagnosed in 2001 for registry certification to CDC and the North American Association of Central Cancer Registries (NAACCR).

RESOURCE REQUIREMENTS:

The following resources are required for the implementation of the cancer surveillance systems:

- Local staff of one program manager, one computer programmer specialist, and four coding clerks;
- Contractual staff for the District of Columbia Cancer Registry Database Management;
- Computer (software and hardware) resources; and
- Local and CDC funding.

DECEMBER 2004 TARGET: By December 2004, gather information on a minimum of 95% of all cancers occurring among District residents during the 2001 calendar year, in order to produce the age-adjusted cancer incidence rates. This target was attained for all sites in 2002 and will be maintained in 2004. Site information for breast, lung, colorectal and prostate cancer will be included in the American Cancer Society Mid-Atlantic Division publication *Cancer Facts and Figures for the Year 2001*.

Focus Area: Diabetes

1) **2010 Goal 13-3:** 80% of District residents with diabetes report having a yearly hemoglobin A1c measurement.

Objective 13-3: Increase to 80% the proportion of District residents with diabetes who report having a yearly hemoglobin A1c measurement.

Baseline 13-3: 69.8% of diabetic residents in the District reported having a yearly hemoglobin A1c in 1997 according to the 1997 Behavioral Risk Factor Survey (BRFSS).

Recommended Action:

According the American Diabetes Association Standards of Care, A1c measurement should be performed routinely on all patients with diabetes first to document the degree of glycemic control over time and then, if needed, to recommend changes in treatment. A yearly A1c measurement is considered the minimum level of care for this procedure.

- The Diabetes Control Program (DCP) will partner with the local primary care clinics to increase the number of people who receive a yearly A1c measurement (and other preventive services).

- By December 2004 all suggested strategies will be implemented.

Rationale:

Nearly, 30% of District residents did not have a yearly A1c measurement in 1997. This represents a substantial proportion of the population that did not receive a basic and necessary procedure.

Strategy:

1. The DCP will assist the primary care clinics in improving their capacity to tract and monitor patients and inform and educate their patients by creating a diabetes registry for patients with diabetes and providing education materials as part of the Health Disparities Collaborative in an effort to increase the rate of eye, foot and A1c exams at selected clinics.

2. The DCP will work with managed care organizations to improve their care for patients with diabetes by serving on committees that will develop regional diabetes care guidelines, diabetes treatment algorithms, and create a regional report card using BRFSS mortality and morbidity data. Outcome measures from the interventions will include the rate of dilated eye exams, biannual A1c testing and influenza immunizations.

Resource Requirements:

- Strong partnerships with community-based organizations, health systems, and primary care providers;
- Two fulltime staff people and funding for promotional and educational materials.

DECEMBER 2004 TARGET:

- As of December 2004, all registries will be established.
- By December 2004, standard of care guidelines will be developed and approved.

2) **2010 Goal 13-5:** 85% of District residents with diabetes report having had a dilated eye exam in the past year.

Objective 13-5: Increase to 85% the proportion of District residents with diabetes who report having a dilated eye exam within the past year.

Baseline 13-5: 78.1% of District residents reported having a dilated eye exam in 1997 (BRFSS).

Recommended Action:

Comprehensive dilated eye and visual examinations should be performed annually by an ophthalmologist or optometrist who is knowledgeable and experienced in the management of diabetic retinopathy for:

- All patients age 10 years and older who have had diabetes for 3–5 years,
- All patients diagnosed after age 30, and
- Any patient with visual symptoms and/or abnormalities.

Rationale:

- In 1997 there were 38 new cases of blindness due to diabetes.
- Diabetes related eye disease is preventable and
- Complications from diabetic eye disease can be minimized, if the appropriate treatment is initiated early on in the disease process.

Strategy:

1. The DCPCP will assist the primary care clinics in improving their capacity to track and monitor patients and inform and educate their patients by creating a diabetes registry for patients with diabetes and providing education materials as part of the Health Disparities Collaborative in an effort to increase the rate of eye, foot and A1c exams at selected clinics.

2. The DPCP will assist managed care organizations in improving their care for patients with diabetes by serving on committees that will develop regional diabetes care guidelines, diabetes treatment algorithms, and create a regional report card using BRFSS, mortality and morbidity data. Outcome measures from the interventions will include the rate of dilated eye exams, biannual A1c testing and influenza immunizations.

Resource Requirements:

- Strong partnerships with community based organizations, health systems, and primary care providers;
- Two full time staff people and funding for promotional and educational materials.

DECEMBER 2004 TARGET:

As of December 2004, the following will have been accomplished:

- All registries will be established.
- Standard of care guidelines will be developed and approved.

3) **2010 Goal 13-6** 75% of District residents report having their feet checked for sores or irritations by a health care professional within the past year.

Objective13-6: Increase to 75% the proportion of District residents with diabetes having their feet checked for sores or irritations by a health care professional in the past year.

Baseline 13-6: In 1997, 57% of District residents with diabetes reported having a foot exam by a health care professional with in the past year.

Recommended Action:

- The American Diabetes Association Standards of Care states that all individuals with diabetes should receive an annual foot examination to identify high-risk foot conditions. This examination should include assessment of protective sensation, foot structure and biomechanics, vascular status, and skin integrity.

- Early recognition and management of independent risk factors for ulcers and amputations to prevent or delay the onset of adverse outcomes.

- By December 2004, all suggested strategies will be implemented.

Rationale:

- In 1997, 43% of all District residents with diabetes did not have a foot exam by a health professional in the past year;

- Additionally, there were 177 lower extremity amputations performed due to diabetes.

Strategy:

- Primary care providers will be targeted as change agents to increase the number of foot examinations performed on patients with diabetes.

    1. DPCP will assist the primary care clinics in improving their capacity to track and monitor patients and inform and educate their patients by creating a diabetes registry for patients with diabetes and providing educational materials as part of the Health Disparities Collaborative in an effort to increase the rate of eye, foot and A1c exams at selected clinics.

    2. The DPCP will assist managed care organizations in improving their care for patients with diabetes by serving on committees that will develop regional diabetes care guidelines, diabetes treatment algorithms, and create a regional report card using BRFSS data, mortality and morbidity data. Outcome measures from the interventions will include the rate of dilate eye exams, biannual A1c testing and influenza immunizations.

Resource Requirements:

- Strong partnerships with community based organizations, health systems, and primary care providers.
- Two full time staff people and funding for promotional and educational materials.

DECEMBER 2004 TARGET:

As of December 2004, the following will have been accomplished:

- All registries will be established.
- Standard of care guidelines will be developed and approved.

Focus Area: Disabilities

1) **2010 Goal 14-1:** 100% of the District of Columbia Department of Health data collection instruments include a standardized set of questions that identify people with disabilities.

Objective 14-1: Include in the core of all relevant District of Columbia Department of Health (DOH) Data collection instruments a standardized set of questions that identify people with disabilities.

Baseline 14-1: Three of sixty programs within the DOH currently collect information that identifies people with disabilities as of 8/2001.

Recommended Actions:

- Evaluate data sources through the examination of: (1) the instruments that DOH programs utilize to collect health related information from District residents, (2) surveys and annual reports, and (3) reports pertaining to the health needs of District residents.

- Provide training and technical assistance to representatives of DOH programs that conduct surveillance activities to enhance their awareness of the need for detailed and current health statistics relative to persons with disabilities.

RATIONALE:

- The paucity of data relative to persons with disabilities "continues to thwart policy analysis and promote an out of sight, out of mind" viewpoint (National Council on Disability, 1996).

- The Americans with Disabilities Act (ADA) is America's legislative attempt to level the playing field to ensure that people with disabilities have equal access to all services and opportunities afforded their non-disabled counterparts in the public and private sector.

- The challenge for the District of Columbia is to create an environment where this can be actualized.

- Presently, lack of detailed and current data about people with disabilities remains an obstacle to effective policy development and analysis both locally and nationally.

- National and local surveys do not routinely collect or report data on people with disabilities the way they collect and report data on other protected groups, i.e., women, the elderly, and people from diverse racial/ ethnic backgrounds.

- Disability and/or morbidity statistics lag well behind many other areas of health statistics *in availability*.

- Therefore, it is vital that all DOH programs that conduct citywide surveys or administer surveillance instruments for data collection purposes include a core set of parameters for collecting information on people with disabilities.

Strategy:

- Identify all of the programs in the Department of Health that conduct surveillance activities and ask that they or a designee attend a meeting to discuss the inclusion of persons with disabilities in their data collection activities. (January, 2002)

- Develop and conduct a current status survey that is designed to examine the extent to which persons with disabilities are included in surveillance activities conducted by the DOH programs. (August-September, 2002)

- Convene a meeting with all identified DOH program representatives to discuss the inclusion of a core set of questions relative to persons with disabilities in relevant surveillance activities. (November, 2002)

- Collect all of the data collection instruments from DOH programs and identify all of the programs that conduct surveillance activities that do not include information about persons with disabilities in their instruments. (December – March 2003)

- Draft a letter of request that disability related questions be included in relevant and pertinent survey instrumentation, that a person be identified who is responsible for the collection of data to serve as a representative for the program to attend a meeting where the feasibility of including this will be discussed. Include a set of recommended questions with the letter. (September, 2003)

- Convene a meeting with all program representatives to discuss the questions to be included in the instruments, and gain commitment that the questions will be incorporated in the existing instruments. (January, 2004)

- Collect and review reports that refer to data obtained from DOH surveys and/or surveillance instruments, (i.e., survey reports, annual reports) to determine the extent to which information on people with disabilities is included in data collection instruments.) (February – May, 2004)

- Conduct Disability Awareness Training for the DOH community outlining the importance of collecting data identifying persons with disabilities. (June – December, 2004)

Resource Requirements:

- To ensure the full implementation of Objective 14.1, it will be necessary to augment our current staff with additional personnel, i.e., database manager, system analyst), and the support of DOH IT personnel.
- In addition, an upgraded computer and relevant software are required to accommodate the data system that will be designed to store the disability data.

DECEMBER 2004 TARGET:

As of December, 2004, 30% of DOH data collection instruments will include questions pertaining to persons with disabilities.

Focus Area: Cardiovascular Disease (formerly Heart Disease and Stroke)

1) **2010 Goal 15-1**: Deaths from heart disease reduced to no more than 230.2 per 100,000 residents.

Objective 15-1: Reduce death from heart disease to no more than 230.2 per 100,000 residents.

Baseline 15-1: In 2000, the age-adjusted mortality rate for heart disease was 273.7 per 100,000 residents in the District of Columbia

RECOMMENDED ACTION:

The Department of Health will develop a Community and Health Systems Cardiovascular Health Needs Assessment. The assessment will provide information on the resources, policies, knowledge, attitudes, and behaviors that affect cardiovascular health in the District of Columbia.

RATIONALE:

Heart Disease is the leading cause of death in the District of Columbia. Risk factors for cardiovascular disease - such as high blood pressure, elevated cholesterol, and overweight - are common among District residents. Risk- reduction strategies need to be taught and monitored.

STRATEGY:

The Cardiovascular Health Program (CHP) is designing an assessment tool to be distributed among health care providers and managed care organizations. Data collected from this assessment tool will enable the CHP to link resources where needed most and streamline efforts among health care providers to better address the burden of cardiovascular disease.

RESOURCE REQUIREMENTS:

Resources for the assessment tool and distribution have already been allocated through the CDC grant for State-based Cardiovascular Health Programs.

DECEMBER 2004 TARGET:

As of December 2004, the Cardiovascular Health Program will complete a District-wide analysis of existing environmental and policy barriers to cardiovascular health. This analysis will investigate health care providers as well as managed care organizations, examining their capacity to meet the burden of cardiovascular disease in the District of Columbia.

This analysis will serve as the foundation for the creation of the State Plan for Cardiovascular Disease.

2) **2010 Goal 15-8:** The rate of death from stroke in the District of Columbia has been reduced to no more than 33.2 per 100,000 residents.

Objective 15-8: Reduce the rate of death from stroke in the District of Columbia to no more than 33.2 per 100,000 residents.

Baseline 15-8: The age-adjusted death rate for stroke was 39.5 per 100,000 residents in 2000.

RECOMMENDED ACTION:

The Department of Health will develop a Community and Health Systems Stroke Needs Assessment. The assessment will provide information on the resources, policies, knowledge, attitudes, and behaviors that affect people who have stroke in the District of Columbia.

RATIONALE:

Cerebrovascular disease is the third leading cause of death in the District of Columbia in 1999. Risk factors for stroke such as high blood pressure, elevated cholesterol, and overweight are common among District residents.

STRATEGY:

The Cardiovascular Health Program (CHP) is designing an assessment tool to be distributed among health providers and managed care organizations. Data collected with this assessment tool will enable the CHP to link resources where needed most and streamline efforts among health care providers to better address the burden of cardiovascular disease.

RESOURCE REQUIREMENTS:

Resources for the assessment tool have already been allocated through the CDC grant for State-based Cardiovascular Health Programs.

DECEMBER 2004 TARGET:

As of December 2004, the Cardiovascular Health Program will complete a District-wide analysis of existing environmental and policy barriers to optimum cardiovascular health. This analysis will investigate health care providers as well as managed care organizations examining their capacity to meet the burden of cardiovascular disease in the District of

Columbia. This analysis will serve as the foundation for the creation of the State Plan for Cardiovascular Disease.

Focus Area: HIV/AIDS

Responsible sexual behavior is a leading health indicator.

1) **2010 Goal 16-5 :** By 2010 approximately 25,000 residents per year will receive HIV antibody testing and counseling services.

Objective 16-5: Increase by 50% the number of residents receiving HIV antibody testing and counseling per year, with focus on women, injection drug users, and persons in jails and prisons.

Baseline 16-5: 16,000 residents received HIV antibody testing and counseling services per year as of July, 2001.

RECOMMENDED ACTION:

To reduce the incidence of HIV/AIDS, the HIV/AIDS Administration (HAA) will heighten awareness of HIV risks and infection, forge partnerships with other agencies and community-based organizations, and provide learning opportunities related to reduction of risks and infection through a comprehensive and aggressive HIV prevention effort in the community.

RATIONALE:

The timely access to HIV antibody testing and counseling, especially in highly affected communities, will increase awareness and knowledge of preventive and protective behaviors that reduce the risk of exposure to infection.

STRATEGY:

- Expand the availability of testing and counseling facilities to Wards 4,5,6, and 8 of the District through partnerships with providers who are rooted in the community as are SHILOH Baptist Church (a faith-based organization), Andromeda, Us Helping Us, Whitman-Walker Clinic and other community-based organizations;

- Intensify testing and counseling in communities experiencing the highest rate of new HIV infection through partnerships with other DOH agencies and community organizations such as the Addiction, Prevention and Recovery Administration; Maternal and Family Health Administration; Department of Corrections; Department of Mental Health; TB/Chest clinics; STD clinics; and others;

- Expand the network of organizations that are willing to work with HAA to provide counseling and testing in non-traditional venues.

RESOURCE REQUIREMENTS:

A total of four full-time employees will be needed to expand the availability of testing and counseling services in targeted wards in the District.

DECEMBER 2004 TARGET:

By December 2004, about 20, 500 residents will have received HIV antibody testing and counseling services, with a special focus on women, injection drug users and persons in jails and prisons.

2) **2010 Goal 16-7** Approximately 600 housing slots are available for residents with HIV/AIDS.

Objective 16-7: By the end of 2004, increase by 20% the number of housing slots designated for persons with HIV/AIDS.

Baseline 16-7: 380 housing slots were available to residents with HIV/AIDS in 2000.

RECOMMENDED ACTION:

Due to the disproportionate impact of HIV in the District of Columbia, HAA continuously administers a comprehensive and aggressive housing program.

RATIONALE:

The significant numbers of persons with HIV/AIDS who are homeless or at risk of homelessness in the District of Columbia pose a threat to continuous provision of care and improvement of quality of life.

STRATEGY:

- Conduct an inventory of HAA funded and non-HAA funded housing slots to identify new and available housing for residents with HIV disease;
- Identify new housing providers who may be interested in providing housing to DC residents with HIV/AIDS;
- Implement the Gatekeepers Program that will integrate and improve access to housing and other supportive services for residents with HIV/AIDS.

RESOURCE REQUIREMENTS:

Three fulltime equivalents (FTE) to coordinate and implement all Housing Program Initiatives will be needed.

DECEMBER 2004 TARGET:

By December 2004, 300 short-term and transitional housing slots will be available for residents with HIV/AIDS. As residents live longer and healthier lives, fewer are faced with homelessness or the risk of homelessness.

3) **2010 Goal 16-3.1:** The number of adult and adolescent residents who have HIV disease receiving early medical intervention and secondary prevention efforts that comply with Public Health Service guidelines will be increased by a minimum of 20%.

Objective 16-3.1: Increase by a minimum of 20% the number of adult and adolescent residents who have HIV disease receiving early medical intervention and secondary prevention efforts that comply with Public Health Service guidelines.

Baseline: In 2001, 850 clients accessed medication through the AIDS Drug Assistance Program (ADAP) and 6180 clients accessed primary medical-related services.

RECOMMENDED ACTION:

Increase and intensify programs that will provide access to lifesaving medications and primary medical and related services to District residents afflicted with HIV.

RATIONALE:

The advent of new treatment modalities and improved medical management of HIV have improved the quality of health outcomes and increased the life expectancy of persons with HIV/AIDS.

STRATEGY:

- Encourage more primary care physicians to refer clients to ADAP through the use of focused awareness-raising regarding ADAP services in media campaigns, outreach and other strategies;

- Increase client's adherence to taking medications in a timely and accurate manner through the Medi-mom Program, a pilot program using pagers to remind clients about taking medications. Also the Medi-mom Program will provide intensive information dissemination using the pagers;

- Improve and increase access to primary care providers through access advocacy and outreach to communities most impacted with HIV/AIDS.

RESOURCE REQUIREMENTS:

- A total of 13 FTEs will be needed to expand primary medical care and related services in the District of Columbia.

- A total of 6 FTEs will be needed to implement ADAP's strategies to increase clients accessing lifesaving HIV medications.

DECEMBER 2004 TARGET:

By December 2004, the number of residents receiving lifesaving medications through ADAP has been increased by 5%. The monthly number of persons accessing ADAP on a monthly basis is 986. The number of those with HIV accessing primary medical care and related services had increased to over 8,000 in 2002.

Focus Area: Immunization

Immunization is a leading health indicator.

1) **2010 Goal 17-3:** Immunization coverage has been maintained at 95% for children in licensed childcare facilities, Head Start Centers, and prekindergarten classes.

Objective 17-3: Maintain immunization coverage at 95% for children in licensed childcare facilities, Head Start Centers, and prekindergarten classes.

Baseline 17-3: Coverage levels for licensed child care facilities in 2001 were 4 DtaP 95%, 3 + Polio 97%, 1 + MMR 97%, 3+ Hib 95%, and 1 Varicella/history 97% according to school survey data. Coverage levels for Head Start centers in 2001 were 4DtaP 91%, 3+Polio 95%, 1+MMR 95%, 3+Hib 91%, and 1 Varicella/history 95% according to survey data. Coverage levels for PreK/K/1 grade students in 2001 were 4 DtaP 92%, 3+Polio 94%, 1+MMR 98%, 3+ Hib not age appropriate, and 1 Varicella/history 91% according to survey data.

Recommended Action:

- To gather data on immunization coverage levels among preschoolers in the District, conduct an annual comprehensive assessment of licensed child care facilities, Head Start centers, and prekindergarten classes for each school year.

- For preschool children not in compliance with school law (immunization of school students - 1979), develop specific recommendations and conduct special immunization clinics when appropriate.

- For improved compliance to the compulsory School Immunization law and to conduct effective activities in areas of greatest need, conduct preschool surveys which are mandatory within this sub-population group.

- To determine immunization levels and trends, enter preschool survey data into the Central Immunization Registry System.

Rationale:

- Uniformly high vaccine coverage levels are required to prevent circulation of the viruses and bacteria that cause vaccine preventable diseases.

- Surveys provide data on coverage levels among the targeted groups in the District.

- Entry requirements for licensed childcare facilities, Head Start Center, and Pre-K classes are some of the most effective interventions there are to ensure preschool

children are appropriately immunized and therefore protected against vaccine preventable diseases.

Strategy:

- Immunization program personnel will conduct annual, comprehensive surveys of licensed childcare facilities, Head Start Centers, and Preschool Kindergarten classes.

- The survey data will be entered into and analyzed by the Central Immunization Registry to determine compliance levels and what additional follow-up is needed.

Resource Requirements:

Commitment and time from immunization program personnel assessment team and the data management program, along with the support of preschool directors and school nurses.

DECEMBER 2004 TARGET:

As of December, 2004, 95% of children attending licensed child care facilities, Head Start centers, and Pre-K classes will have completed specific coverage rates for selected antigens.

2) **2010 Goal 17-7:** 100% of each new birth cohort is enrolled in the Central Immunization Registry.

Objective 17-7: Increase to 100% (minus any deaths) of each new birth cohort enrolled in the Central Immunization Registry.

Baseline 17-7: This project began in the year 2001. Baseline data indicate that 76% (5,683 of 7,513 births, based on 1999 births to District women) of the cohort was enrolled in the Central Immunization Registry by the end of 2001.

RECOMMENDED ACTION:

- The State Center for Health Statistics Administration (SCHSA) will transmit a data file including agreed upon fields for all new births to District residents to the DC Immunization Program's Central Immunization Registry System on a monthly basis.

- The Immunization Registry will add the new births' information from the file.

- Measurement of the percentage of new birth cohorts will be based on the number of new births in the Immunization Registry, compared with the number of new births reported by the SCHSA for the last available reporting year.

RATIONALE:

- The national *Healthy People 2010 o*bjective 14-26 is to "increase the proportion of children who participate in fully operational population-based immunization registries."

- One of the key components of a fully operational population-based immunization registry according to *Healthy People 2010* and the Centers for Disease Control and Prevention's National Immunization Program is that it enrolls "all children at the state or community level automatically at birth. Consequently, the immunization status of all children will be accessible to state officials and administrators.

- The most cost-effective, non-duplicative and complete means of enrolling children at birth is to use birth certificate information already collected for Vital Records.

STRATEGY:

- Representatives of the SCHSA will transmit data on a monthly basis in the agreed upon format to the DC Immunization Program's Registry .

- The applicable information then will be added to the Registry system, thereby enrolling the birth cohort in the Immunization Registry.

RESOURCE REQUIREMENTS:

Commitment and time from SCHSA staff members and its data management team and from the DC Immunization Registry team to use already established information systems and equipment to collect, transmit, and analyze birth data.

DECEMBER 2004 TARGET:

As of December 2004, 78% of the year 2003 birth cohort will be enrolled in the Central Immunization Registry.

3) **2010 Goal 17-9:** 90% of non-institutionalized adults aged 65 years and older are vaccinated annually against influenza and have been immunized against influenza. 60% of non-institutionalized adults ages 65 years and older are immunized against pneumococcal disease.

Objective 17-9: Increase to 90% the proportion of non-institutionalized adults aged 65 years and older immunized against influenza; and increase to 60 % the number of non-institutionalized adults ages 65 years and older immunized against pneumococcal disease.

Baseline 17-9: BRFSS* coverage level data for 2002 indicated that 61% of non-institutionalized adults 65 and older were immunized with influenza vaccine and 48.3% of non-institutionalized adults 65 and older were immunized with pneumococcal vaccine.

(Source: * Delmarva Foundation - Preventive health services delivered to Medicare Patients in the District of Columbia).

RECOMMENDED ACTION:

- Identify, through hospital discharge records, high-risk people and those 65 and older who need influenza and/or pneumococal vaccine;

- Motivate non-institutionalized high risk adults and those 65 and older through appropriate verbal, visual, or printed messages to consider having influenza and/or pneumococcal vaccine;

- Improve the availability of outreach community clinics for influenza and pneumococcal vaccine coverage for high-risk patients and those 65 and older who are underinsured or without Medicare coverage;

- Improve performance of physicians and other healthcare providers in avoiding missed opportunities to immunize high-risk adults and those 65 years and older with influenza and pneumococcal vaccine during contacts with health care providers in offices, outpatient clinics, and hospitals.

RATIONALE:

- One of the national Healthy People 2010 objectives, 14-29, is to increase annual influenza rates and improve the use of pneumococcal vaccine in non-institutionalized adults ages 65 and older.

- "Vaccination is an effective strategy to reduce illness and deaths due to pneumococcal disease and influenza."

- With the adult population living longer, increasing numbers of adults will be at risk for these major causes of illness and death.

- According to the national *Healthy People 2010* and the Centers for Disease Control and Prevention, "continued education of providers and the community is needed to increase awareness of and demand for adult vaccination services."

STRATEGY:

- To promote collaboration and cooperation among Public Health agencies, community organizations and private providers in vaccinating high-risk individuals and those 65 and older as an efficient and effective use of resources;

- Utilize the Central Immunization Registry for a computer generated reminder system to private and public providers for high-risk patients and those over 65 years of age;

- Improve education and outreach to older adults, especially those 65 and older and adults with underlying health conditions, by addressing concerns about the lack of information, as well as the myths and misunderstandings concerning influenza and pneumococcal vaccines and fear based on past reactions.

RESOURCES REQUIRED:

Commitment and time from the Immunization Program, Delmarva Foundation, and the District's Office of Aging to work together and improve direct services, education and the exchange of ideas on improving influenza and pneumococcal vaccine levels in adults 65 and older and all adults with an underlying health condition.

DECEMBER 2004 TARGET:

As of December 2004, 65% of high-risk adults or those 65 years and older will be vaccinated annually with influenza vaccine, and 50%, if needed, with pneumococcal vaccine.

Focus Area: Mental Health

Mental Health is a leading health indicator.

The Department of Mental Health

In the past five years the Department of Mental Health (DMH) emerged from oversight by a Receiver (1997), Transitional Receiver (2000), to the end of Receivership (2002). The Department's current oversight includes a Director and Court Monitor.

The primary mission of DMH is to address the mental health services and support needs of District residents. To accomplish this mission, DMH is structured with a separation between its Authority role (policy maker for the mental health system) and its provider components: DC Community Services Agency (public provider of core, specialty and other services) and Saint Elizabeths Hospital (public provider of a variety of inpatient services).

The Mental Health Authority's role involves planning and policy development, certification of qualified service providers, licensure of mental health facilities; quality improvement; provider oversight, administration of the mental health rehabilitation services (MHRS) program; development of systems of care for adults, children and youth; enforcement of consumer rights; and organizational development and training.

The DC Community Services Agency has been certified as a Core Services Agency (CSA) and Specialty Provider along with other community providers. The provider network is responsible for providing MHS to adults, children, youth and their families.

Saint Elizabeths Hospital currently provides forensic inpatient services and acute and long-term care for non-forensic adults. The Hospital will gradually move toward the sole provision of tertiary care (3-12 months) for individuals who need the structure and security of a public mental hospital. Acute care, as planned, will primarily be provided under agreements with local hospitals. The Hospital will continue to provide forensic inpatient services. Plans are also underway for the construction of a new inpatient facility.

Services for District Children, Adolescents and Their Families

1) **2010 Goal 18-1:** A community support system for children or youth with mental health problems and their families is being developed through collaboration in the administration, financing, resource allocation, training, evaluation and delivery of services across all appropriate public systems.

Objective 18-1.5: Expand to provide comprehensive school-based mental health services to another set of identified schools (n=14 by 2003, total n = 40).

Baseline 18-1.5: As of September 2002, a full complement of prevention, early intervention, and treatment services were available in 10 Charter Schools and 16 DC Public Schools out of a total of 35 Charter Schools and 147 Public Schools serving District residents.

RECOMMENDED ACTION:

- Develop a community support system for District children and youth with mental health problems and their families through collaboration in the administration, financing, resource allocation, training, evaluation and delivery of services across all appropriate public systems.

- DMH, as part of its overall mission, will continue to seek federal and private funding to fully evaluate and where possible conduct survey, outcomes, and clinical research on the efficacy of child and youth initiatives. The DMH is currently evaluating child initiatives through the DC Children Inspired Now Gain Strength (CINGS) Project, a federal grant funded under the Child Mental Health Initiative.

- Part of the DMH mission should be to encourage and advocate that its academic partners seek research opportunities that focus on our changing system.

RATIONALE:

- Prevention, early intervention, and mental health services and mental health supports to meet individual and special needs (1) are delivered in natural, nurturing and integrated environments, (2) recognize the importance of and support for the maintenance of enduring family relationships, and (3) are planned and developed within the District and as close to the child's or youth's home as possible, so that families need not relinquish custody to secure treatment for their children and youth.

- During the day, District children and youth of school age are generally accessible in the school setting. Consequently, mental health (MH) services should be accessible in schools where coordinated efforts to create a nurturing and supportive environment are ongoing and where interventions are more likely to be effective.

STRATEGY:

1) A needs assessment and resource mapping will occur for each of the targeted schools.

2) Mental health staff will be hired and trained to provide school-based services.

3) A standardized mental health referral and triage system will be approved and utilized in the schools.

4) A program to include prevention, early intervention, and treatment services will be operational in DC Public and Charter Schools.

RESOURCE REQUIREMENTS:

1) Staff positions to include 31 clinical, 2 supervisory, 1 program assistant, and 1 director;
2) Cellular phones for all clinical staff; and
3) Therapeutic equipment, training materials, and office supplies to supplement clinical work.

DECEMBER 2003 TARGET: By December 2003, approximately 14% of DC Public Schools (n=147) and 32% of Public Charter Schools (n=35) will have a full complement of mental health prevention, early intervention, and treatment services available to children and their families.

DECEMBER 2004 TARGET: By December 2004, approximately 5 transformation schools will be added to the School Mental Health Program, resulting in about 17% of DC Public Schools (n=147), and 32% of Public Charter Schools (n=35) will have a full complement of mental health prevention, early intervention, and treatment services available to children and their families.

Services for Adult Residents of the District of Columbia

2) 2010 Goal 18-2.1: An adult mental health system of care has been developed that provides responsive outreach and mental health services to persons in the District who are homeless and have a mental illness.

Objective 18-2.1: Expand the number of service contracts to persons who are homeless and have a mental illness in the District to 35,944 during 2003.

Baseline 18-2.1: The target of 23,246 service contacts for persons who are homeless and mentally ill in the District was exceeded in FY 2002. A new target of 35,944 service contacts was set for 2003.

RECOMMENDED ACTION:

- Explore the feasibility of enhancing the rates for services provided to persons who are homeless and have mental illness by the DMH Core Service Agencies (CSAs);

- Provide infrastructure support to assist 2 specialized homeless service provider agencies to become certified as DMH Mental Health Rehabilitation Services (MHRS) providers;

- Train Core Service Agency staff on billing procedures for outreach and engagement under the new DMH MHRS system.

RATIONALE:

- DMH has recently converted to a Mental Health Rehabilitation Option and District funded fee for service system designed to maximize and promote services to persons with mental illness that are difficult to engage and treat.

- Despite this, during the initial conversion process, there are indications of difficulties in some service agencies in making the conversion from a grant/contract-funded system to a fee for service system.

- An unintended result has been the need for training, and additional financial incentives to continue to increase services to persons who are homeless and have a mental illness in the District.

- As with other cities during the recent economic downturn, the number of homeless people is increasing. An increased effort is needed to engage them in services and provide housing and other supports to persons who are homeless and have a mental illness.

STRATEGY:

The following strategies will be employed:

1) Develop an enhanced DMH policy on outreach and engagement that includes, but is not limited to persons who are homeless and have a mental illness to set clear responsibilities and requirements for DMH CSAs. Review all certified providers' outreach and engagement policies, and admission and discharge policies for compliance with the DMH policy once established;

2) Provide training to the Assertive Community Treatment (ACT) teams on procedures for enrolling persons who are in need of engagement into the MHRS system and billing for services to persons even when basic identifying and demographic information may not be available;

3) Provide infrastructure support to certify 2 provider agencies as DMH MHRS providers that specialize in providing services to persons who are homeless and have a mental illness;

4) If feasible, increase the rates for DMH MHRS Community Support Services contacts when providing services to persons who are homeless and have a mental illness.

RESOURCE REQUIREMENTS:

- The DMH will provide the necessary MHRS training on the provision of outreach and engagement services to persons who are homeless and mentally ill.

- Forty thousand dollars ($40,000) in Mental Health Block Grant funds is targeted to provide infrastructure support for 2 homeless service providers to become certified as DMH MHRS providers.

- The DMH will develop policy and review outreach, engagement, admissions and discharge policies of certified providers in the DMH system of care.

DECEMBER 2003 TARGET: By December 2003, there will be 35,944 service contacts provided to persons who are homeless and have a mental illness in the District of Columbia.

DECEMBER 2004 TARGET: By December 2004, develop and implement a training curriculum for homeless service providers and DMH Core Service Agencies. The topics will include outreach and engagement, resources, mental health issues in the homeless population, addiction, cultural competence and other issues. The DMH and homeless service providers will serve as trainers, outside speakers as appropriate will be invited, and certificates provided.

Another activity for 2004 will be to continue to refine the system for tracking unduplicated persons who are homeless and face-to-face contacts.

Services to Homeless People with Serious Mental Illness Who are 18 Years of Age and Older

3) **2010 Goal 18-2.2:** Increased numbers of safe, decent, affordable housing units are available for adult residents of the District of Columbia who have a mental illness to promote their recovery from mental illness and their ability to live in the least restrict living environment of their choice.

Objective 18-2.2a: Develop 50% more housing units dedicated for residents of the District who have a mental illness in 2003 than were developed with DMH capital and operating funding in FY 2002.

Objective 18-2.2b: Develop 100% more housing units dedicated for residents of the District who have a mental illness in 2004 than were developed with DMH capital and operating funding in FY 2003.

Baseline 18-2.2: The DMH Housing Division will develop and implement an enhanced strategic business and financing plan to promote the development of additional affordable housing units for persons with a mental illness.

RECOMMENDED ACTION:

The DMH Housing Division will develop and implement an enhanced strategic business and financing plan to promote the development of additional affordable housing units for persons with a mental illness.

RATIONALE:

- In order to provide effective treatment and supports that promote the recovery of District residents from serious mental illness, the DMH must make available to those residents safe, affordable housing that will enable them to live successfully in the community.

- The new DMH Mental Health Rehabilitation Services system promotes individually-based services to the extent needed to allow persons with mental illness to live independently in the community. The DMH supportive housing initiative provides these "wrap around" services to persons who hold their own leases and have rights and responsibilities as tenants.

- Given the limited income of the majority of persons with serious mental illness in the District and the scarcity of decent, safe, affordable housing, DMH has developed a Capital and Operating fund to provide funding to develop new affordable housing units that have below market rental rates and may be subsidized by bridge and permanent rental subsidies.

STRATEGY:

1) DMH has launched a new supportive housing initiative to increase the number of decent, safe, affordable housing units developed and to better leverage its capital funds with other District and Federal housing grants and low interest financing opportunities.

2) Instrumental in this effort is strengthening the partnership with other District agencies involved with the Mayor's plan to expand affordable housing opportunities to residents of the District, especially the DC Housing Authority, Department of Housing and Community Development, and Department of Housing Finance and Office of Economic Development.

3) DMH will also develop and assist in the implementation of a uniform application for housing development funds to be used across District agencies.

4) DMH is convening a multi-agency housing advisory committee and work group to guide and revise the Department's housing plan and initiative.

RESOURCE REQUIREMENTS:

- Three (3) FTE DMH Housing Division staff and .5 FTE Director of Adult Services are required to manage the supportive housing initiative, plan development and rental subsidy program.

- One hundred fifty thousand dollars ($150,000) in consultant services are required to develop and implement the uniform housing development funding application form and develop an improved financing model.

DECEMBER 2003 TARGET: By December 2003, there will be 150 additional new housing units developed.

DECEMBER 2004 TARGET: By December 2004, there will be 328 additional new housing units developed.

Focus Area: Sexually Transmitted Diseases

Responsible sexual behavior is a leading health indicator.

1) **2010 GOAL 19-3:** The incidence of primary and secondary syphilis is reduced to no more than 3 cases per 100,000 people in the District.

OBJECTIVE 19-3: Reduce the incidence of primary and secondary syphilis in the District to no more than 3 cases per 100,000 people.

BASELINE 19-3: The primary and secondary syphilis rate in the general population of the District of Columbia was 7.1 per 100,000 people in the year 2000.

RECOMMENDED ACTION:

The STD Program expects to reduce primary and secondary syphilis among District residents by:

- Expanding screening sites;
- Educating more women;
- Continuing safe sex presentations during counseling sessions in clinical settings; and
- Providing patients with male and female condoms.

RATIONALE:

- The rate of spread of communicable diseases in a population is determined by three factors: (1) the rate of exposure of susceptible persons to infected individuals, (2) the probability that an exposed, susceptible person will acquire the infection (i.e., the "efficiency of transmission"), and (3) the length of time that newly infected person remains infected and is able to spread the infection to others." (Source: Anderson, 1991: "The Hidden Epidemic: Confronting Sexually Transmitted Diseases," Thomas R. Eng and William T. Butler, editors, 1997, Institute of Medicine, National Academy of Science.)

- "Interventions can prevent the spread of an STD within a population by reducing the rate of exposure to an STD. A sustained prevention program can drive the infection to extinction in the entire population, even when these interventions are provided only to individuals and social networks with the highest rates of transmission." (Source: Anderson, 1991: "The Hidden Epidemic")

STRATEGY:

- Ensure that all STD morbidity and case-related data are entered into the case records within 24 hours of closure;

- Ensure that at least 95% of in-jurisdiction reactive serologies are reported within 24 hours of the date the test result is read;

- Ensure that at least 95% of all early syphilis cases diagnoses are entered into the surveillance system without mistakes within 24 hours of interview;

- Interview 90-95% of early syphilis cases reported yearly;

- Ensure that a minimum of .70 new sex partners are referred, examined and given preventive or therapeutic treatment for each case of syphilis interviewed;

- Ensure that at least 95% of epidemiological and administrative staff in the District's public STD clinic receives one or more training sessions during the year;

- By September 1, 2004, ensure that at least 95% of the major providers in the District are in possession of CDC guidelines for the treatment and management of STD infections;

- By December 31, 2004, ensure that the Division receives at least 95% of all positive syphilis reports within 24 hours of test result;

- By December 31, 2004, conduct active syphilis surveillance by assigning liaisons to visit four critical "sentinel" providers at least twice a week - Howard University Hospital, Providence Hospital, the DC Detention Center, and Washington Hospital Center. These liaisons will provide active surveillance by reviewing laboratory reports, medical records, and Emergency Room logs at these sites on a weekly basis for STD test results, demographic data and symptom indications. These sites were selected because they are all located in high morbidity areas and each has difficulty providing information to the Division in an expedient manner.

RESOURCE REQUIREMENTS:

(Approximately) 2 million annually to cover costs for personnel, buildings, utilities, and laboratory support.

DECEMBER 2004 TARGET: As of December, 2004, the incidence of primary and secondary syphilis is reduced to no more than 13.0 cases per 100,000 people. (In 2002, the incidence of primary and secondary syphilis was 10.1 per 100,000 people.)

2) **2010 GOAL 19-4:** The incidence rate for congenital syphilis has been reduced to no more than 10 cases per 100,000 live births.

OBJECTIVE 19-4: Reduce the incidence of congenital syphilis to no more than 10 cases per 100,000 live births.

BASELINE 19-4: The incidence rate for congenital syphilis in the year 2000 was 52.0 per 100,000 live births.

RECOMMENDED ACTION:

The STD Program expects to reduce primary and secondary syphilis among District residents by:

- Expanding screening sites;
- Ensuring timely treatment and counseling;
- Educating more women and men;
- Continuing safe sex presentations during counseling sessions in clinical settings; and
- Providing patients with male and female condoms.

RATIONALE:

- "The rate of spread of communicable diseases in a population is determined by three factors: (1) the rate of exposure of susceptible persons to infected individuals; (2) the probability that an exposed, susceptible person will acquire the infection (i.e., the "efficiency of transmission"); and (3) the length of time that newly infected person remains infected and is able to spread the infection to others."

- "…Interventions can prevent the spread of an STD within a population by reducing the rate of exposure to the STD. A sustained prevention program can drive the infection to extinction in the entire population, even when these interventions are provided only to individuals and social networks with the highest rate of transmission" (Anderson, 1991: The Hidden Epidemic).

STRATEGY:

- Ensure that all STD morbidity and case-related data are entered into the case records within 24 hours of closure;

- Ensure that at least 90% of in-jurisdiction reactive serologies are reported within 24 hours of the date the test result is read;

- Interview 90-95% of early syphilis cases reported yearly;
- Ensure that a minimum of .70 new sex partners are referred, examined and given preventive or therapeutic treatment for each case of syphilis interviewed;
- Ensure that at least 95% of epidemiological and administrative staff in the District's public STD clinic receives one or more training sessions during the year;
- By September 1, 2004, ensure that at least 95% of the major providers in the District are in possession of CDC guidelines for the treatment and management of STD infections;
- By December 31, 2004, ensure that the Division receives at least 95% of all positive syphilis reports within 24 hours of test result;
- By December 31, 2004, conduct active syphilis surveillance by assigning liaisons to visit 4 critical "sentinel" providers - Howard University Hospital, Providence Hospital, the DC Detention Center, and Washington Hospital Center - at least twice a week. These liaisons will provide active surveillance by reviewing laboratory reports, medical records, and Emergency Room logs at these sites on a weekly basis for STD test results, demographic data and symptom indications. These sites were selected because they are all located in high morbidity areas and each has difficulty providing information to the Bureau in an expedient manner.

RESOURCE REQUIREMENTS:

(Approximately) 2 million annually to cover costs for personnel, buildings, utilities, and laboratory support.

DECEMBER 2004 TARGET: As of December 2004, the incidence rate for congenital syphilis has been reduced to no more than 26 cases per 100,000 residents.

3) **2010 GOAL 19.1:** The proportion of women testing positive for Chlamydia trachomatis in the District's STD Clinic has been reduced by 3.28% and in the family planning clinics by 4.92 percent.

OBJECTIVE 19-1: Reduce the proportion of women in the District of Columbia testing positive for Chlamydia trachomatis infections in the STD Clinic by 3.28% and in family planning clinics by 4.92%.

BASELINE 19-1: The proportion of women in the District of Columbia testing positive for Chlamydia trachomatis infections in the STD Clinic was 6.0% (146 of 2,426) and in family planning clinics 3.8% (112 of 2,858) in 2000.

RECOMMENDED ACTION:

Reduce chlamydia positivity rates of women by:

- Expanding screening sites;
- Educating more women and men;
- Continuing safe sex presentations during counseling sessions in clinical settings; and
- Providing patients with male and female condoms.

These recommended actions are based on the success demonstrated in several states in the Pacific Northwest where extensive screening began in family planning clinics in 1988 and in STD clinics in 1993 and prevalence declined from 12% to 10% in the late 1980s and from 5% to 4% in 1995.

RATIONALE:

"Pelvic Inflammatory Disease (PID) is among the most serious threats to female reproductive capability. PID is caused most frequently by chlamydia infections and gonorrhea that ascent past the cervix into the upper reproductive tract… PID often results in scarring and either complete or partial blockage of the fallopian Tubes" (*Healthy People 2010, pp. 25-21-25-22).*

The DC Chlamydia Project proposes to meet the 2004 prevention target of 86 cases of PID by identifying women with chlamydia for treatment purposes. Treating these chlamydia-infected women will result in the prevention of 86 cases of PID with an estimated economic benefit of $100, 362.00 ($1,167.00 per case) projected for 2004.

STRATEGY:

On August 31, 2000, a letter from the Department of Health (DOH) was sent to all laboratories and primary health care providers advising them of a reinterpretation of the DC Codes regulating laboratory reporting and physician reporting that would now include chlamydia as a reportable sexually transmitted disease. This reinterpretation requires that laboratories detecting positive chlamydia results shall report the positive test to the Division of STD Control using the same protocols and timeframes currently used to report syphilis and gonorrhea. This also requires that physicians or other health care providers responsible for a case of chlamydia should report treatment information on the case.

RESOURCE REQUIREMENTS:

Southeast STD Clinic requires $150,000 annually for screening for chlamydia approximately half of which is used to support the contract with Planned Parenthood of Metropolitan Washington.

DECEMBER 2004 TARGET: As of December 2004, the proportion of women testing positive for Chlamydia trachomatic in the District's STD Clinic has been reduced by at least 0.5% to 5.5% and in the family planning clinics by at least 0.5% to 2.41%.

Focus Area: Substance Abuse

Substance abuse is a leading health indicator.

1) 2010 GOAL 20-1: No more than 50% of youth report ever having tried cigarette smoking.

OBJECTIVE 20-1: Reduce to no more than 50% of the proportion of youth who have ever tried cigarette smoking.

BASELINE 20-1: 56.7% of boys and girls have tried smoking, according to the 2001 District of Columbia Youth Risk Behavior Survey (YRBS).

RECOMMENDED ACTION:

- Implement plan to educate District residents on preventing the abuse of alcohol, tobacco and other drugs (ATOD);
- Provide vendor education and in-store display materials to 500 merchants to comply with regulations prohibiting tobacco sales to minors;
- Encourage and assist in the development of community coalitions and new programs on ATOD prevention;
- Provide classroom presentations to students in public and charter schools on the hazards of tobacco use;
- Sponsor and partner with other public and private entities addiction awareness events, i.e., an annual Awareness Day, community health fairs, and youth specific events.

RATIONALE:

- Daily the number of District youth reported to have ever tried cigarette smoking increases.
- There is a correlation between the number of teens who smoke cigarettes and the number of teens who smoke marijuana.
- Nationally, each day, 4,000 new youth report smoking their first cigarette.

STRATEGY:

- Distribute 500,000 pamphlets on alcohol, tobacco and other drugs (ATOD) abuse prevention to residents;
- Distribute substance abuse prevention information throughout District neighborhoods, including District public and charter schools, in order to reach 35,000 youth;
- Conduct outreach, community presentations and health fairs, in order to reach 50,000 residents;

- Provide training on substance abuse prevention to 500 persons including staff of community-based organizations, school personnel, faith leaders, parents, and other youth workers;
- Award 10-15 grants to community-based organizations to provide prevention programs to children, youth and families; to develop and implement community-based and environmental strategies for ATOD prevention.

RESOURCE REQUIREMENTS:

- Continuation of the distribution of tobacco compliance videos, literature, and counter mats to vendors;
- Continued annual compliance checks of approximately 1,200 merchants;
- Continued partnerships with tobacco control office, private sector health associations, and District of Columbia public schools;
- Block grant funds to award grants to community-based organizations for the conducting of ATOD prevention programs.

DECEMBER 2004 TARGET: As of December 2004, 53.9% of boys and girls report having tried smoking (a decrease of 5% from 56.7% in 2001).

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2) **2010 GOAL 20-2:** No more than 51% of youth report that they have ever drunk alcohol.

OBJECTIVE 20-2: Reduce to 51% the proportion of youth who have ever drunk alcohol.

BASELINE 20-2: Of District youth 58.9.5% reported drinking alcohol according to the 2001 District of Columbia YRBS.

RECOMMENDED ACTION:

- Provide workshops and presentations to youth enrolled in after school programs;
- Enhance adolescent's refusal skills for alcohol and other drugs through classroom presentations, prevention workbooks and materials.

RATIONALE:

- While the drinking rates for District of Columbia high school students are below the national average (according to the federal Centers for Disease Control), prevention of alcohol use by the city's young people remains a paramount issue.

- The District of Columbia has the third highest per capita alcohol consumption rate in the nation, according to the *1999 Facing Facts: Drugs and the Future of Washington, DC,* issued by Drug Strategies.

STRATEGY:

- Provide prevention education at 15 of the District's Public Schools Transformation Schools and at the District's public charter schools;
- Empower youth through education and knowledge to change their attitudes toward ATOD use;
- Enhance adolescent's refusal skills for alcohol and other drugs;
- By 2010, reduce by 5% the proportion of young people who have used alcohol, marijuana and cocaine in the past month.

RESOURCE REQUIREMENTS:

- Use of block grant funds to award grants to community-based organizations to conduct ATOD prevention programs;
- Acquisition and dissemination of drug prevention literature from national clearinghouses;
- Continued partnerships with District public and charter schools;
- Increased staff and consultant capacity;
- Increased enforcement by Alcohol and Beverage Control agents and District police of ban on sales to minors.

DECEMBER 2004 TARGET: As of December 2004, 56% of District youth will report having had one or more drinks during their lifetime (a decrease of 5% from 58.9% in 2001).

3) 2010 GOAL 20-3: No more than 20% of youth report that they have ever used marijuana.

OBJECTIVE 20-3: Reduce to 20% the proportion of youth who have ever used marijuana.

BASELINE 20-3: Of District of Columbia youth, 36.5% reported use of marijuana one or more times during their lifetime, according to the 2001 DC YRBS.

RECOMMENDED ACTION:

- Educate youth and community residents about risk factors for potential drug use;
- Strengthen protective factors to produce resiliency in youth;
- Raise awareness of parents and the community about the level of youth involvement with marijuana and provide strategies they can use to influence youth drug-taking behavior.

RATIONALE:

- Marijuana is a gateway drug and may possibly lead to use of other illicit drugs.
- The overall use of marijuana has deceased; however, the rate of use remains high for District students in the 12th grade.
- Marijuana usage by youth can be cut by reducing the number of teens who smoke cigarettes.
- Prevention of marijuana use may lead to the prevention of additional ATOD use.

STRATEGY:

- Provide substance abuse prevention education at 50% of the District's public and charter schools;
- Provide educational material to 100,000 District youth and adult residents on the harmful physical effects of marijuana use;
- Conduct 24 workshops for children and youth participants in after-school programs.

RESOURCE REQUIREMENTS:

- Utilize block grant funds to award grants to community-based organizations to conduct ATOD prevention programs.
- Acquire and disseminate drug prevention literature from national clearinghouses.

DECEMBER 2004 TARGET: As of December 2004, 34.7% of District youth will report having used marijuana one or more times during their lifetime (a decrease of 5% from 36.5% in 2001).

Focus Area: Tuberculosis

1) **2010 GOAL 21-1:** The incidence of tuberculosis in the District of Columbia has been reduced to no more than 9.9 cases per 100,000 people.

OBJECTIVE 21-1: Reduce the incidence of tuberculosis (TB) in the District of Columbia to no more than 9.9 cases per 100,000 people.

For Asian/Pacific Islanders, because the incidence of 0.18 cases per 100,000 people in 2002 is lower that the 2010 target (of 1.5 cases per 100,000), ensure that this incidence rate is maintained and not allowed to increase by 2010.

For African Americans, from 10.5 cases per 100,000 people in 2002 to 10 cases per 00,000 people in 2010.

For Hispanics, from 2.7 cases per 100,000 people in 2002 to 2.3 cases per 100,000 people in 2010.

For American Indian/Alaska Natives, because the incidence of 0.18 cases per 100,000 people in 2002 is lower than the 2010 target (of 0.5 cases per 100,000), ensure that this incidence rate is maintained and not allowed to increase by 2010.

BASELINE 21-1: 13.7 cases of tuberculosis per 100,000 people in 1999.

RECOMMENDED ACTION:

- Continued collaboration with hospitals, clinics, shelters, correctional facilities and other locations where TB patients and those at risk for TB receive services to (1) identify TB cases and (2) ensure timely, appropriate and complete treatment for their TB;
- Targeted screening of populations that are likely to have high rates of latent TB infection, so that preventive treatment can be offered.

RATIONALE:

- TB is transmitted from person to person.
- Early identification and treatment of infectious TB cases will prevent transmission to other persons, decreasing the number of infected persons who may develop active (infectious) TB in the future.
- Identification and treatment of persons with latent infection who are at increased risk of developing active disease will prevent future TB cases.

STRATEGY:

- Providing targeted screening of populations that are likely to have high rates of latent TB infection, so that preventive treatment can be offered.

RESOURCE REQUIREMENTS:

- Continued funding for current program personnel;
- Increased program capacity to provide consultation, training, technical assistance to local health care providers.

DECEMBER 2004 TARGET: By December 2004, the incidence of tuberculosis in the District of Columbia will have been reduced from 13.7 cases per 100,000 people to 12.0 cases per 100,000.

2) **2010 GOAL 21-2:** 90% of close contacts of persons with active tuberculosis complete the recommended preventive therapy.

OBJECTIVE 21-2: Increase to 90% the proportion of close contacts of persons with active tuberculosis who complete the recommended courses in preventive therapy.

BASELINE 21-2: Less than 10 percent of close contacts of persons with active tuberculosis completed preventive therapy in 1999.

RECOMMENDED ACTION:

- Increase efforts to screen, educate and treat high-risk close contacts.
- Offer directly observed preventive treatment where TB Control Program resources permit (e.g., for family members of case patients receiving Direct Observed Therapy or DOT).

RATIONALE:

- DOT has substantially improved treatment completion rates for TB cases.
- Close contacts of TB cases come from the same population and have the same risk factors for failure to complete recommended treatment.

STRATEGY:

- Increase the monitoring of active case management/ contact investigation to assure all efforts are made to locate and assess named contacts;
- Improve access to preventive therapy;

- Establish collaborative relationships with area community-based health centers catering to high-risk populations.
- Strengthen the program's cross-cultural capabilities.

RESOURCE REQUIREMENTS:

- Augmentation of existing TB Control Program data management systems to allow tracking of contacts on Directly Observed Preventive Therapy (DOPT).

DECEMBER 2004 TARGET: As of December 2004, 50% of close contacts completed recommended preventive therapy.